Baseline and Best Practices Assessment of Seven SIBASI in El Salvador: Phase I and II

December 2002

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Funded by:
U.S. Agency for International Development

Order No. TE 017

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- *Design and implementation of health information systems for disease surveillance.*
- *Delivery of quality services by health workers.*
- *Availability and appropriate use of health commodities.*

December 2002

Recommended Citation

Seiber, Eric. December 2002. *Baseline and Best Practices Assessment of Seven SIBASI, El Salvador, Phases I and II*. Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

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Contract/Project No.: HRN-C-00-00-00019-00

Submitted to: USAID/San Salvador

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Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

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Acronyms

AIEPI	*Atención Integral a los Menores de Cinco Años* (Integrated Care for Children under 5 Years)
AOP	Annual Operating Plan
ETZ	Zone Technical Teams (*Equipos Técnicos Zonales*)
FESAL	National Family Health Survey (*Encuesta Nacional de Salud Familiar*)
GTZ	German Technical Cooperation
HIS	Health Information System
MMR	Measles, Mumps, Rubella
MSPAS	*Ministerio de Salud Pública y Asistencia Social* (Ministry of Public Health and Social Assistance)
NGO	Non-governmental Organization
PAHO	Pan American Health Organization
PHR*plus*	Partners for Health Reform*plus*
SIBASI	*Sistemas Básicos de Salud Integral* (Basic Integrated Health Systems)
SPA	Service Providers Assessment
STI	Sexually Transmitted Infection
USAID	U.S. Agency for International Development

Currency Conversion 8.75 colones = 1 US$

Executive Summary

When the El Salvadoran Ministry of Public Health and Social Assistance (MSPAS) began its dramatic and comprehensive reorganization in 2000, it recognized the need for a systematic approach to track its progress in implementing the reorganization. As a result, MSPAS is developing multiple activities to monitor progress and has solicited the participation of the U.S. Agency for International Development (USAID) in these activities.

As a resource for the administrators of the new basic health integrated health systems (*Sistemas Básicos de Salud Integral*, SIBASIs), USAID commissioned its Partners for Health Reform*plus* (PHR*plus*) project to conduct a baseline and best practices assessment of the seven SIBASIs supported by USAID/El Salvador.

This baseline and best practices assessment will contribute to the Ministry's ability to capitalize on the identified successes of the newly integrated health systems, facilitate the communication and replication of best practices, and strengthen the newly formed SIBASIs so they can become fully functional in the shortest time possible. The analysis is designed to provide up-to-date in formation on the status of implementing the SIBASI model so that each actor associated with implementation can make informed decisions on how to improve the process.

Assessment Sample and Methodology

The assessment team conducted the baseline and best practices assessment of the seven USAID-priority SIBASIs in two phases. In Phase I, the study team conducted a series of in-depth interviews with each of the SIBASI directors and members of their technical teams. In Phase II, the study team adapted a shortened version of the MEASURE/Evaluation project's Service Providers Assessment to identify best practices, resources, and challenges facing the new SIBASIs.

The Phase II facility interviews were conducted for nine weeks in July through September 2002. A random sample of hospitals and health centers (health units and health posts) was drawn from the seven SIBASIs with an under-sampling of health posts in a separate stratum. The final sample included 67 percent of hospitals and health centers in the first stratum and 34 percent of health posts in the second stratum. With correct weighting for the health posts, the sample allows representative estimates for the seven SIBASIs.

Phase I

The first phase of the analysis focused on the process of implementing the SIBASI model. SIBASI staff express a common belief that the SIBASI model differs from previous reforms. Unlike the previous health departments that some considered a miniaturization and replication of the central Ministry offices in San Salvador, the SIBASI is believed to be fundamentally different.

By May 2002, only a few months into the actual implementation of the SIBASI model, the Ministry already had multiple achievements. The implementation discussion in this analysis focuses on five primary ones.

Achievement #1: Creating functioning SIBASI management committees

All SIBASIs have succeeded in incorporating representatives from the hospital, SIBASI administration, and health centers into their functioning management committees, producing entities that have been a key force in changing the culture of MSPAS at the local level.

Achievement #2: Establishing SIBASI administration and technical staff as well as zone technical teams (ETZ)

All seven SIBASIs have established their administrative offices and identified staff for the technical teams. Each SIBASI administration has established itself in its respective locality and begun the transition to the SIBASI model, with its new relationship to MSPAS providers.

Achievement #3: Defining SIBASI geographic and population responsibilities

Through the ETZs, the Ministry initiated a countywide study of patient utilization patterns and identified and created lists of facilities that would constitute each SIBASI. SIBASI leaders took ownership of this activity and now use the facility list as a planning tool to continuously refine population responsibilities and geographic scope.

Achievement #4: Creating a new and effective referral/counter-referral system

All seven SIBASIs have successfully created and are implementing an effective referral/counter-referral system. The process of creating this system also helped to integrate primary and tertiary level services within SIBASIs and expand cooperation among different SIBASIs.

Achievement #5: Distributing and using the SIBASI administrative manual

MSPAS used a participatory process to develop and disseminate the new SIBASI administrative manual by January 2002. The administrative manual has been extremely effective in informing MSPAS staff about the SIBASI model and establishing a common vocabulary around the SIBASI concept. It has been less successful, however, in providing guidance on how to implement the model.

Phase II

The second phase of the analysis focused on the SIBASI health facilities, with its findings organized around each of the 11 SIBASI components identified from the administrative manual.

1. Planning

The SIBASIs share a well-developed planning process, but opportunities exist to improve the planning targets and to better integrate plans between the SIBASI primary care providers and their respective hospitals. All SIBASIs create annual plans and set service delivery targets for their catchment population. Health center directors pay close attention to these plans and targets in order to effectively meet their coverage targets. These annual plans, however, are based on the supply of services rather than demand by catchment population. In addition, coverage targets do not always reflect national protocols.

2. Management

The new management structures of the SIBASIs are the direct results of the SIBASI reforms. All SIBASIs have directors and functioning management committees in place. SIBASI health center leaders

also perform some key management functions. The new SIBASI management demonstrates both initiative and leadership, and the committees have already gained substantial experience.

But SIBASIs have also encountered challenges that were unforeseen during the conceptual development of the SIBASI model. Challenges stem from the over reliance on medical students in health center management positions and the fact that many roles and responsibilities are still unclear. Finally, there is minimal participation of non-MSPAS representatives on the SIBASI management committees.

3. Finance

The SIBASIs inherited some financial oversight mechanisms from the departments, but they also were given some authority to administer finances in a way that would improve efficiency in resource utilization. However, at the health center level, there is an imbalance, in the allocation of salaries across facilities and SIBASIs, and a large percentage of salaries at the facility level are dedicated to community-based providers.

4. Regulation

The transition of the regulatory framework to the new SIBASI model has begun although much work remains. MSPAS has started the process of updating protocols in support of the SIBASI integrated health care model, but dissemination of protocols has been limited, and therefore provider use of new children's and women's health protocols has been limited.

5. Health Information System

All SIBASIs have a functioning and standardized health information system (HIS) in place, but the HIS is not yet realizing its full potential in terms of both data collection and use. The focus of data collected has not shifted to the SIBASI model of integrated care. Almost all health centers track and report common preventive care visits and incidence of disease, but the quality of data collected by the HIS is weak. Finally, data collected for the HIS are not utilized to provide needed information.

6. Human Resources

Full control over human resources has yet to be devolved to the SIBASIs, but staffing will present challenges to all SIBASIs. All health centers can count on at least one staff member from each cadre of health professionals at the delivery site. Only half of the medical staff are fully paid by MSPAS. Finally, key clinical personnel spend approximately one-third to one-half of their time in non-clinical activities.

7. Supervision and Oversight

SIBASI administrators actively monitor health centers through direct visits and statistical oversight, although the current system lacks a clear focus. A majority of health centers receive supervisory visits on a regular basis, but there are no clear standards and expectations for what supervisors should do when visiting a facility. Once the monitoring responsibilities are more clearly defined, the HIS, however, does provide an active and functioning system to monitor both SIBASI and facility activities.

8. Supplies and Logistics

Health centers have experience in managing their own drugs only or all inventory, although the actual distribution of pharmaceuticals remains a department and regional activity. Supply and logistics management has not decentralized to the SIBASI level. Storage conditions for commodities at the facility

level are good, but health centers experience frequent stock-outs on critical commodities. Facilities/health centers often do not receive all the supplies and commodities requested.

9. Social Participation

Systematic social participation is a fundamental difference between the SIBASI model and the previous department model, and the SIBASIs have made strong efforts to develop this new component. SIBASI administrators are reaching out to community leaders. The majority of facilities hold meetings with the community, and many facilities make changes in response to community input. Finally, SIBASIs frequently requested direction and assistance in how to implement the social participation component.

10. Maintenance and Infrastructure

As the SIBASIs assume responsibility for facility maintenance, creative approaches will be needed to improve upon the current maintenance performance. At the time of the assessment, maintenance responsibilities remained at the department level. All SIBASI facilities are functioning with basic services, but the current maintenance system is inadequate to prevent interruptions of basic services. In addition, SIBASI-wide maintenance systems do not exist.

11. Service Provision of Basic Health Services

SIBASI health centers provide a broad range of basic health services, but the new SIBASI model will require additional development of outreach services. Most centers offer extended hours of services, and each facility offers a broad range of primary care services. Temporary family planning contraceptive methods are available. SIBASI facilities have strong community-based children's health services, but SIBASIs offer limited primary health care services in community settings.

Next Steps

This SIBASI baseline and best practices assessment will be disseminated to multiple audiences in a variety of venues to ensure that all relevant actors have the data and the opportunity to discuss its implications. The first dissemination event was held in September 2002 in San Salvador with the MSPAS leadership and the directors of the seven USAID priority SIBASIs. MSPAS has programmed other dissemination activities, including the following:

- A one-day conference in February 2003 to present the results to a wide audience.
- One-on-one seminars with the directors and administrative teams from each of the seven USAID priority SIBASI.
- Bimonthly or quarterly meetings of the seven SIBASI directors to exchange ideas and discuss best practices in implementing the SIBASI model.
- In collaboration with MSPAS leadership, PHR*plus* will assist in the development of a monitoring and evaluation system for SIBASIs.

1. Introduction

1.1 Antecedents to Baseline and Best Practices Assessment

When the El Salvadoran Ministry of Public Health and Social Assistance (MSPAS) began its dramatic and comprehensive reorganization in 2000, it recognized the need for a systematic approach to track its progress in implementing the reorganization. As a result, MSPAS is developing multiple activities to monitor progress and has solicited the participation of the U.S. Agency for International Development (USAID) in these activities.

As a resource for the administrators of the new basic health integrated health systems (*Sistemas Básicos de Salud Integral*, SIBASI), USAID commissioned its Partners for Health Reform*plus* (PHR*plus*) project to conduct a baseline and best practices assessment of the seven SIBASIs supported by USAID/El Salvador. This assessment draws upon and complements the evaluations and baselines conducted over the last two years by the Pan American Health Organization (PAHO) and German Technical Cooperation (GTZ), as well as the ongoing activities of the central Ministry and the MSPAS zone technical teams (*equipos técnicos zonales, ETZs*). All of these activities share the goal of providing objective information for evidence-based decision making.

1.2 Goal and Objectives of Baseline Assessment

Study Targets

The study is intended to contribute to the Ministry's ability to capitalize on the identified successes of the newly integrated health systems, facilitate the communication and replication of best practices, and strengthen the newly formed SIBASIs so they can become fully functional in the shortest time possible. This information will also help the Ministry play a stronger leadership role in strengthening the national health system at all levels.

Assessment Objectives

1. Provide information on current levels of implementation of the SIBASI model and a means to monitor and evaluate the evolving implementation of the components and systems in the SIBASI model.

2. Provide data for future quality improvement activities including service delivery, infrastructure, utilization, and medicine stock-outs.

3. Identify best practices that can be utilized in both horizontal and vertical capacity building and advocacy.

4. Allow the tracking of indicators for USAID priority health services.

1.3 Audiences and Proposed Uses of Baseline Assessment

There are multiple audiences for the baseline assessment. They include leadership at MSPAS headquarters, SIBASI directors and their administrative teams, MSPAS zone technical teams, USAID/El Salvador, and USAID cooperating agencies and other donors who support and provide technical assistance to strengthen SIBASI institutional capacity. The analysis is designed to provide up-to-date information on the status of implementing the SIBASI model so that each actor associated with implementing the model can make informed decisions on how to improve its design and implementation:

- MSPAS leadership can use the analysis to monitor the status of the SIBASI implementation and make adjustments to the process and model as necessary.
- SIBASI directors can identify where their respective SIBASI is in the implementation process, identify the strengths and weaknesses, and develop strategies for improvement.
- USAID, other donors, and collaborating agencies, in collaboration with MSPAS, can use the data to design technical assistance that will expand the SIBASIs' institutional capacity to build on their strengths and address their weaknesses.

To ensure that all the relevant actors have the needed data and understand the implications of the data, results of the SIBASI baseline analysis are being disseminated in a variety of venues. The first event took place in September 2002 in San Salvador, when PHR*plus* facilitated two meetings that presented preliminary findings to MSPAS leadership and directors of the seven USAID-priority SIBASIs. In a subsequent meeting, also facilitated by PHR*plus*, MSPAS leadership and the SIBASI directors met to discuss findings from the data analysis and suggest next steps. A second dissemination event will be held in February 2003. PHR*plus* and MSPAS will hold a one-day conference to present the results to a wide audience that will include a larger group of MSPAS headquarters staff, SIBASI directors and their administrative teams, and other international organizations working to support SIBASIs. Finally, PHR*plus* will hold one-on-one seminars with each of the seven SIBASI directors and their entire administrative teams to present the results to their respective SIBASIs.

1.4 Structure of the Assessment

This baseline report consists of five sections. This first section introduces the antecedents, goal, and objectives of the assessment. The second section discusses the study sample and analysis methodology. The third section draws on the results from the first phase of the assessment, the qualitative data collection and focuses on the progress to date in implementing the SIBASI model. The fourth section, based on findings of the second phase of the study, quantitative data collection, documents the local capacity available to the SIBASIs through their health centers, focusing on SIBASI capacity in each of the 11 components of the SIBASI model. The interview guide and questionnaire for each phase of the study can be found in the annexes. The fifth and final section of the assessment discusses next steps to integrate the findings into processes that strengthen implementation in the seven priority SIBASIs.

2. Assessment Sample and Methodology

2.1 Introduction

The assessment team conducted the baseline and best practices assessment of the seven USAID-priority SIBASIs in two phases: Phase I emphasized the steps taken to date to implement the new SIBASI model; data was gathered in contextual interviews with SIBASI leaders in May 2002. Phase II emphasized the resources and processes actually available in each SIBASI as it begins its mission of providing integrated basic health care to its population. To collect this data, the assessment team conducted interviews to retrieve quantitative data with facility directors in July through September 2002. This document analyzes the findings from both phases of the data collection process. The assessment methodology and sample are discussed below.

2.2 Phase I – Qualitative Survey

In Phase I, the study team conducted a series of in-depth interviews with each of the SIBASI directors and members of their technical teams. The interview team guaranteed participants' anonymity and explained that all findings reported in the final analysis needed to be reported by multiple SIBASI staff. Each interview ran approximately two-and-one-half hours, with questions pertaining to the SIBASI staff's understanding of the SIBASI model, the quality of communication from central level MSPAS leadership regarding the SIBASI model, administrative processes inherited from the departments, and their assessment of the decentralization process. The original interview guides can be found in Annex A.

2.3 Phase II – Quantitative Survey

In Phase II, the study team adapted a shortened version of the MEASURE/*Evaluation* project's Service Providers Assessment (SPA) to identify best practices, resources, and challenges facing the new SIBASIs. This instrument covered a range of subjects from general facility information to logistics and specific primary care services and produced a snapshot in time of MSPAS services in this one geographic area. The complete facility questionnaire can be found in Annex B.

This facility questionnaire was designed to act as a screening tool to identify the different components of MSPAS primary care facilities and how those components interact. The exploratory nature of the individual questions allows the identification of best practices and challenges commonly found in many SIBASI facilities. The same exploratory nature of questions precludes sufficient detail in any one section to identify specific solutions to challenges identified. Based upon the findings of the assessment tool, each SIBASI can tailor future investigative efforts to address challenges identified in this first screening assessment.

2.4 Sample Size

Facility interviews were conducted for nine weeks in July through September 2002. A random sample of hospitals, health units, and health posts was drawn from the sample frame summarized in Table 1, with an undersampling of health posts in a separate stratum. The final sample included four hospitals

(seven in population), 69 health units (106 in population), and 14 health posts (41 in population). Nutrition posts and the nutrition clinic were excluded from the sample frame. The final sample included 67 percent of hospitals and health centers in the first stratum and 34 percent of health posts in the second stratum. With correct weighting for the health posts, the sample allows representative estimates for the seven SIBASIs.

Table 1: Health Facilities in Sample, by SIBASI

SIBASI	Hospitals	Health Units	Health Posts	Nutrition Posts	Airport Clinics	Total Facilities
Cojutepeque	1	11	9	0	0	21
Suchitoto	1	2	3	0	0	6
La Paz	1	28	10	10	1	50
San Vicente	1	15	3	2	0	21
Jiquilisco	1	10	2	1	0	14
Usulutan	1	15	3	2	0	21
San Miguel	1	25	11	1	0	38
Total	7	106	41	16	1	171

Note: As the SIBASIs refine reference patterns, they have frequently passed facilities to neighboring SIBASIs. Table 1 uses the March 2002 geographic definitions.

2.5 Challenges with Survey Instruments and Data Collection

The methodology utilized provided a strong foundation for the analysis presented in this assessment. Both phases of data collection utilized strong instruments with indicators tested across multi-country studies. Phase II applied the latest facility questionnaires developed by USAID's flagship MEASURE/*Evaluation* project. Because well-trained data collection teams were able to proceed smoothly and quickly across the study area, this current assessment is able to identify the salient findings relevant to this current phase of SIBASI implementation.

Several challenges in the data collection and analysis phases merit attention:

- The quantitative sections of the report include only health centers.
- Hospitals were removed when conducting the analysis. This decision was made to prevent distortion of the findings for the health centers due to averaging in the much larger hospitals.
- Several questions in the instruments needed to be revised due to discrepancies in translation after 20 percent of the health centers had been interviewed. These health centers were re-interviewed and only the revised questions were included in the subsequent interview.
- One health center, accessible only by boat, was dropped from the sample. This facility was replaced by the next closest facility in the same SIBASI.
- Care must be taken not to generalize the results to El Salvador as a whole; it is very likely that the urban SIBASIs in the San Salvador area differ greatly from the seven largely rural SIBASIs in this assessment.

3. Analysis of SIBASI Implementation and Achievements to Date

3.1 Overview

This section draws on the results from the first phase of the analysis and focuses on the progress to date in the *process* of implementing the SIBASI model. The section begins with an overview of the policy creating the SIBASIs and a brief description of the SIBASI model and concludes with a discussion of the five distinct achievements, each of which represents a substantial change in the operating culture of the Ministry:

- Creating functioning SIBASI management committees
- Establishing SIBASI administration and technical staff as well as zone technical teams
- Defining SIBASI geographic and population responsibilities
- Creating a new and effective referral/counter-referral system
- Distributing and using the SIBASI administrative manual

3.2 Description of Decentralization Process

Over the 12-month period from mid-2001 to early 2002, the MSPAS proceeded with its commitment to decentralization reforms with the announcement of the creation of 28 SIBASIs. The current SIBASI structures reflect a decade-long process of increasingly more decentralized management. The process began a decade ago with the division of the five administrative health regions into more decentralized offices coinciding with El Salvador's 14 departments. In the last reform, the 14 department administrations were subdivided into 28 basic integrated health systems (SIBASIs), coinciding with the 28 national secondary care hospitals. The formal announcement of the individual SIBASIs represents a scaling-up from the three pilot SIBASIs in operation since 1999. In support of the new reforms, USAID/El Salvador has concentrated its support in seven of these new SIBASIs.[1]

3.3 Achievements to Date in Implementing SIBASI Reforms

By May 2002, only a few months into the actual implementation of the new SIBASI model, the Ministry already had multiple achievements. Many additional achievements could be added to the list, but the implementation discussion will focus on the five primary achievements listed above.

It should be noted that, rather than remaining in a continuous planning stage, the Ministry has already implemented reforms only contemplated in many countries. In field offices, SIBASI staff express a common belief that the SIBASI model differs from previous reforms. Unlike the departments that were

[1] Cojutepeque, Suchitoto, La Paz, San Vicente, Jiquilisco, Usulutan, and San Miguel.

considered a miniaturization and replication of the Ministry offices in San Salvador, the SIBASI is believed to be fundamentally different. A near universal belief exists at the SIBASI level among field staff that these reforms will produce something fundamentally different.

Achievement #1: Creating functioning SIBASI management committees

The creation and operationalization of the SIBASI management committees has been a key force in changing the culture of MSPAS at the local level. All SIBASIs have built upon their success in creating the SIBASI facility lists and the initial integration resulting from the new referral system and have succeeded in incorporating representatives from the hospital, SIBASI administration, and health centers into their functioning management committees.

Each SIBASI has adopted a variation of two models to create its management committee. Smaller SIBASIs have adopted a model that includes representatives from all health centers while larger SIBASIs have tended to organize networks of health centers with representatives selected from each network. Some management committees also include representatives from community-based MSPAS providers. As of May 2002, every SIBASI included only MSPAS providers.

Although all SIBASIs have functioning management committees, Section 4.2 - Management Component presents multiple dynamics that remain unresolved. These dynamics include the following:

- The inclusion of non-MSPAS personnel in the management committees
- The relationship between the SIBASI director and the management committee
- The evaluation of health center representatives by technical team committee members
- The relationship between long-term headquarters staff and one-year facility directors

By opening a decision space at the local level for the SIBASI management committees, the Ministry has fundamentally shifted the nature of MSPAS personnel at the local level. First, the management committee has increased the spirit of cooperation among health centers, with facility directors seeing their specific problems in a more global perspective by realizing the competing needs within the SIBASI. Second, the same management committees have led to further integration of primary and secondary care providers as well as increased coordination among primary care providers. Finally, SIBASI directors have noted that jointly solving problems through the management committee has produced a new initiative and ownership of problems not previously seen amongst administrators and staff. All of these advances have chipped away at the strong hierarchical culture that was pervasive in MSPAS.

Achievement #2: Establishing SIBASI administration and technical staff as well as zone technical teams

All SIBASIs have established their administrative offices and identified staff for the technical teams. With the establishment of a facility list for each SIBASI, the Ministry proceeded to formally commit itself to the SIBASI model by naming directors and technical teams for each of the 28 SIBASIs. Each of these SIBASI administrations has established itself in its respective locality and begun the transformation of MSPAS providers to the SIBASI model.

SIBASI administration composed of the director, a three-person technical team, and a five-person administrative team. The actual number of individuals in each SIBASI administration ranges from as few as four to as many as 25 and 30.

The size of technical teams does not correspond with population size and number of facilities within each SIBASI. Although each SIBASI has an administration in place, the number of staff assigned to each SIBASI administration varies. In its conceptual form, the SIBASI administrative manual outlines a

The general determinant of the size of a SIBASI administration has been its location relative to the old department office. If a department had a single hospital, then that department was converted into a single SIBASI that inherited all the staff in the department's administration. These SIBASIs have large technical and administrative teams.

If a department had multiple hospitals and was subdivided to form multiple SIBASIs, the SIBASI based in the old department office retained all administrative staff with only an occasional individual reassigned to the second (or third) outlying SIBASI formed from the department. These outlying SIBASIs typically have three to seven staff on the technical team and no staff for their administrative team. All administrative functions remain with the SIBASI based in the old department offices.

A negative consequence of the imbalance in distribution of staff is the number of people available to perform SIBASI duties. One SIBASI may have half the number of staff as a neighboring SIBASI with similar population and facility responsibilities. SIBASI directors that inherited large administrations are reluctant to reassign the extra staff to health centers. Their most frequently cited concern stemmed from their uncertainty of the number of staff that would actually be needed to run a SIBASI. One director explained that, while three people may be sufficient for his technical team, on any given day all but one of these team members have been called away to a meeting at the Ministry or sent to a training session. Other directors explained that they were uncertain how the staff at the Ministry would operate in the new framework. One SIBASI administrator reported that 70 percent of staff time is dedicated to answering the daily demands from the central Ministry and only 30 percent is dedicated to actually developing the SIBASI. SIBASI administrators reported some frustration with the high level of demands coming from the central Ministry.

Although the ETZ have been established, their roles and responsibilities are still unclear. The purpose of the ETZ, as listed in the SIBASI manual, is to serve as a resource and interface between the SIBASI and the central level Ministry. Although multiple SIBASI directors volunteered that the legal advisors on the ETZs had proved invaluable, a general consensus exists that the larger ETZs as a whole had yet to develop into their new role as a resource for the SIBASIs. Directors also stated that members of the ETZs remain uncertain about their new roles and continue to conduct the same supervisory visits that were part of their old responsibilities in their previous positions at the department level. Much of this overlap between the ETZ and SIBASIs stems from the fact that the SIBASIs did not yet exist as formal legal entities in May of 2002.

Achievement #3: Defining SIBASI geographic and population responsibilities

MSPAS has successfully devolved decision making to all SIBASIs to define geographic scope and population responsibilities. As a first step to actually implementing the new SIBASI model, in 2001 the Ministry tasked ETZs with initiating a countywide study of patient utilization patterns. This study considered which communities utilized each health center and which health centers referred their clients to what hospitals. Based on the utilization patterns observed in the study, the Ministry created a SIBASI around each of the 28 national hospitals from the health centers and populations that correspond to each respective hospital.

All SIBASIs, including the seven USAID priority SIBASIs, have successfully defined their geographic and population responsibilities and reorganized accordingly. From the initial utilization studies, the Ministry and ETZs produced a list of facilities that would constitute each SIBASI. From this

working list, they assigned each health center, health post, and rural nutrition post to a SIBASI and its affiliated hospital. In addition to assigning health facilities, the list identifies which municipalities correspond to each SIBASI and lists each case where a community corresponds to a different SIBASI than its municipality. This facility list has served as a useful communication device and prevented confusion by clarifying which health centers correspond to which SIBASI administration. The facility list also serves as a foundation for planning and resource allocation decisions.

SIBASI leaders have taken ownership of this activity and use the facility list as a planning tool to continuously refine population responsibilities and geographic scope. After reporting initial findings, ETZs, and now the SIBASIs, have continued to analyze utilization patterns. Although ETZs initially handled health center and community assignments, the SIBASIs have now taken over ownership of this activity. SIBASIs have subsequently traded and reassigned both health centers and communities based on their continuing understanding of utilization patterns. The rapid adoption of this assignment and reassignment process bodes well for future successes in SIBASI implementation.

Fundamental to this success in defining SIBASI geographic and population responsibilities is the fact that the Ministry devolved the decision-making authority. With a clear statement, supported by action that it would not manage the utilization studies and facility assignment, the Ministry created a clear space for local decision making. With these clear signals from the Ministry, the SIBASIs stepped forward to manage the process and accept responsibility. In this important step in the implementation of the SIBASI model, the Ministry successfully delegated responsibility to the SIBASI level and adopted a role as steward rather than its previous centralized management approach.

Achievement #4: Creating a new and effective referral/counter-referral system

All seven SIBASIs have successfully created and are implementing an effective referral/counter-referral system. This process exemplifies MSPAS leadership creating space for SIBASIs to take initiative in addressing a priority problem. Although this process varied across SIBASIs, the general process remained similar. For these seven SIBASIs, the initial referral/counter-referral system was developed in meetings between health center directors and hospital staff. In some areas, SIBASI directors subsequently met to standardize their approach to referrals between primary and secondary care providers. Since implementing the system, SIBASI directors have maintained a dialogue on its strengths and weaknesses and, based on their evaluations, are contemplating subsequent refinement.

The process to create the referral/counter-referral system has helped integrate primary and tertiary level services within SIBASIs. Creating the new referral system has stretched well beyond the presence of a functioning referral mechanism, establishing dialogue and cooperation that rarely existed previously between health centers and the autonomous hospitals. This new communication and cooperation between primary care providers and the autonomous hospitals has also reaped other benefits such as facilitating the creation of the SIBASI management committees and serving as the cornerstone of hospital/health center integration.

The creation of the referral system has expanded cooperation among SIBASIs. Having established contacts in the refinement of the SIBASI facility lists, SIBASI directors have been able to continue their joint cooperation with the standardization of referral systems and joint evaluations of their common systems.

Achievement #5: Distributing and using the SIBASI administrative manual

MSPAS used a participatory process to develop and disseminate the new SIBASI administrative manual. This process helped create the current environment whereby all staff are well informed about the

structure and requirements of the SIBASI model. The first concrete resource available to the SIBASI directors and staff was the administrative manual distributed to the SIBASIs in January of 2002. This manual outlines a conceptualization on how a SIBASI will function and the responsibilities that local administrators will have.

Most SIBASI staff interviewed for this baseline and best practices assessment either had a colleague involved or were themselves involved in the development of this manual. This participatory approach to the administrative manual's development and its subsequent dissemination workshops allowed MSPAS staff a period of adjustment before the manual's final distribution. SIBASI staff encountered few surprises when they received the bound version.

SIBASI staff actively use the new manual as a resource while implementing the decentralization process. Throughout the interviews, staff continually referred to the concepts detailed in the manual. The manual has contributed a common understanding among all MSPAS staff and established a common vocabulary around the SIBASI concept, limiting unnecessary confusion.

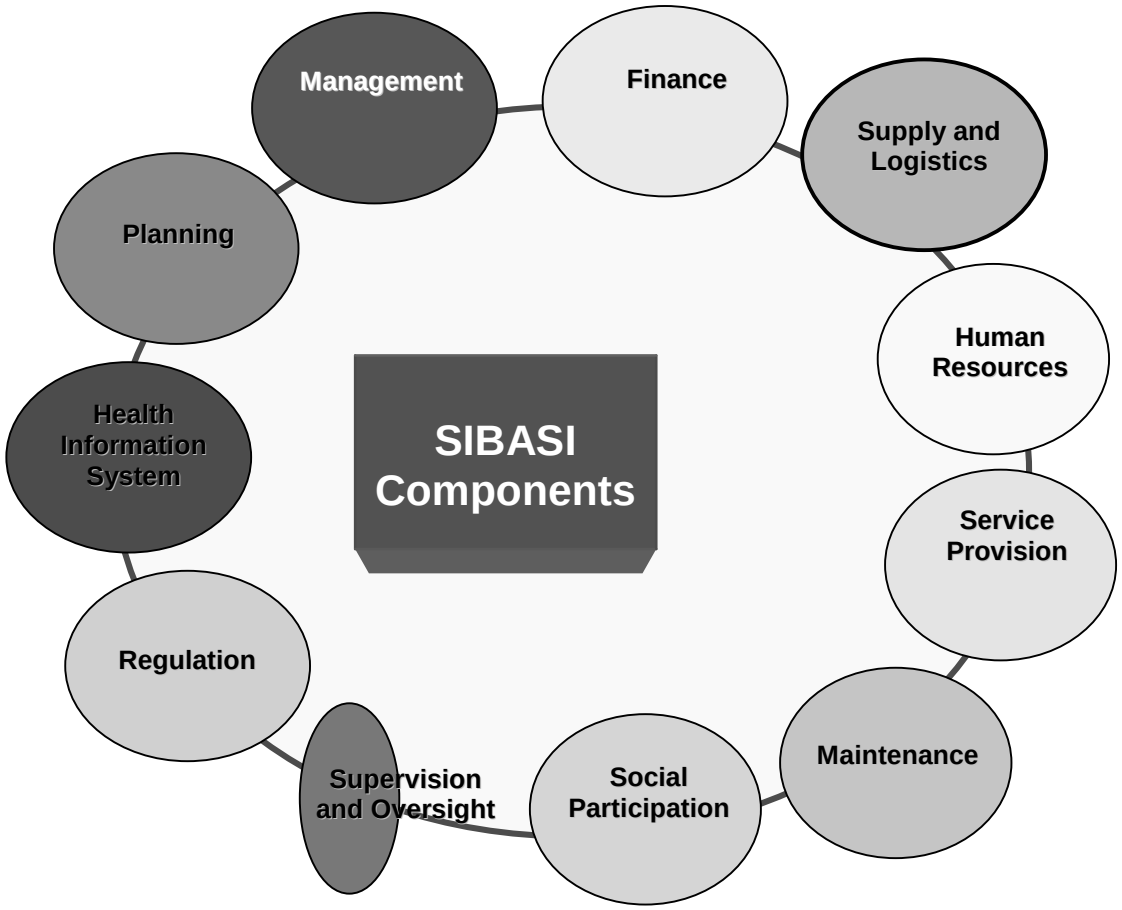
The administrative manual has been extremely effective in informing MSPAS staff about the SIBASI structure and requirements of the model but has been less successful in providing guidance on how to implement the model. As a result of using the manual, SIBASI staff have developed multiple suggestions towards improving the administrative manual and its utilization. SIBASI staff repeatedly requested a decision or clarification on how the Ministry wants structures implemented or whether the central Ministry would allow these structures to be developed at the local level. For components where the manual provided fewer details, SIBASI directors want to know whether subsequent guidelines will be distributed from the Ministry or whether this is a space reserved for the SIBASIs to decide as they deem fit. A frequently cited example relates to social participation. Although the SIBASIs have their own ideas on how to proceed, they are reluctant to act because they are concerned that if they begin implementation of this component and the Ministry subsequently mandates a different approach, they will suffer a loss of credibility within the community. The SIBASIs have adopted a wait-and-see stance as a result.

4. Analysis of 11 SIBASI Components

4.1 Introduction to Analysis of all SIBASI Components

This section presents the findings from Phase II of the data collection, which focused on the SIBASI health facilities. The findings are organized around each of the 11 SIBASI components identified from the administrative manual (Figure 1). Each section contains a brief overview paragraph, a summary of the component from the SIBASI manual, and a description of the key findings on that particular component.

Figure 1: Components of SIBASI Model



4.2 Planning Component

4.2.1 Overview of Planning

The SIBASIs share a well-developed planning process, but opportunities exist to improve the planning targets and to better integrate plans between the SIBASI primary care providers and hospital. The following are the elements of the planning process:

- All SIBASIs conduct annual planning and set service delivery targets for their catchment population.
- SIBASI directors use plans and targets effectively to meet coverage and other targets.
- Planning is linked to supply of services and not demand by catchment population.
- Coverage targets do not reflect national protocols.
- Further integration is needed between planning targets for health centers and hospitals.

4.2.2 Description of Planning from SIBASI Administrative Manual

As conceived in the SIBASI manual, the planning system allows for annual planning activities and the development of projects with non-Ministry funds. Within this framework, annual planning comprises the development of a tactical plan, an annual operating plan (AOPs), the monitoring of these plans, and an analysis of statistical performance. Before the baseline assessment began, all SIBASIs had submitted tactical plans to the Ministry, so this assessment focused on the AOPs. Project development with non-Ministry funds was not included in the best practices assessment.

4.2.3 Key Findings

Finding #1: All SIBASIs conduct annual planning and set service delivery targets for their catchment population.

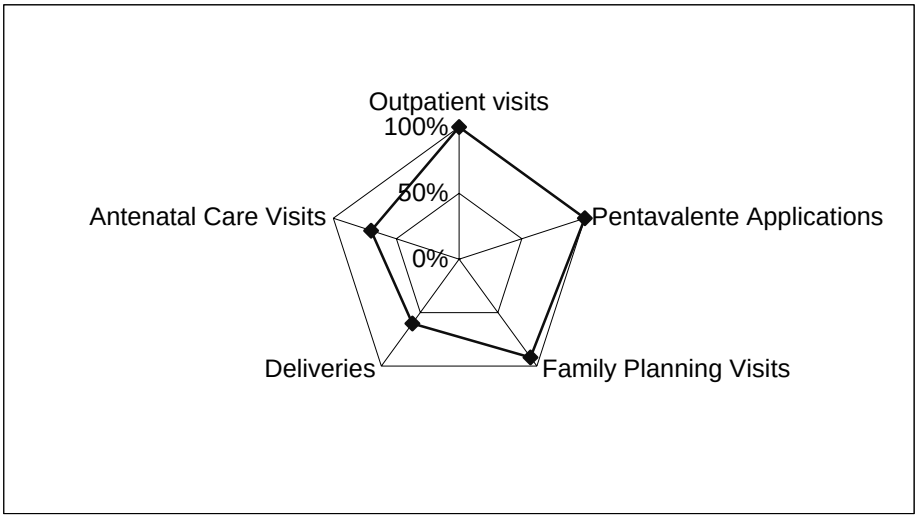
The planning process in use predates the SIBASI reforms. Before the creation of the new SIBASIs, the departments prepared their own annual operating plans and distributed facility-specific versions to their individual health centers. With the elimination of the departments, the SIBASIs are responsible for developing AOPs. In these annual plans, specific targets are set for all categories of clinical visits, producing targets for the number of vaccinations given, outpatient visits, surgeries, well-baby visits, dengue sprayings, and so forth.

Finding #2: SIBASI directors use plans and targets effectively to meet coverage and other targets.

Figure 2 indicates that health centers exert substantial effort to meet the targets set for them by the SIBASI. For the seven SIBASIs that are the focus of the current study, the median clinic exceeds its planned total outpatient visits by 27 percent, and achieves a 119 percent coverage of its Pentavalente vaccine goal. Despite these strong achievements relative to total outpatient and child health targets, the typical clinic falls short in family planning and maternal health services. Most notably, the family

planning goal coverage reaches 92 percent, but prenatal visits are substantially lower at 70 percent, and deliveries achieve only 60 percent of the planned goal.

Figure 2: Coverage of Planning Targets by Health Centers



It is important to note that although the hypothetical median facility (i.e., that represents the statistical average for all functions) came close to achieving its targets, the majority of facilities are very far from the targets planned by the SIBASI. One-quarter of facilities had coverage rates of less than 78 percent for outpatient visits, while another quarter of health centers' coverage rates exceeded 186 percent of their annual targets. SIBASIs will need to closely monitor which facilities are experiencing high/low utilization and may need to respond by shifting staff and resources away from underutilized facilities.

Despite positive achievements in planning such as SIBASI ownership of the planning process and effective use of plans and targets to achieve, many challenges remain. These challenges are described in Findings #3, #4, and #5 below.

Finding #3: Planning is linked to supply of services and not to demand by catchment population.

SIBASI directors currently determine the production goals of SIBASIs and the health centers from one of the three following criteria:

- Historical usage
- Staff availability weighted by expected productivity per employee
- Norms for consultations per individual in the facility catchment area

Very few health centers are assigned targets that reflect the local population's demand for services. Within the same SIBASI, one health center may receive a production goal three times higher than another center that has a similar population responsibility.

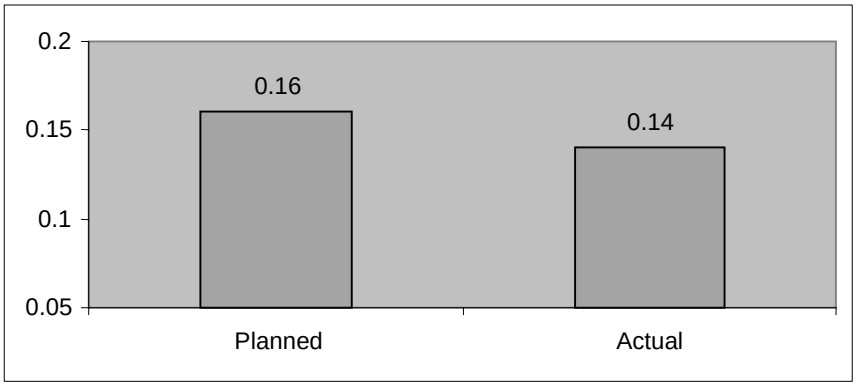
Since population responsibilities vary, the analysis converted all targets to account for each facility's population responsibility. Planned visits were divided by the official population assigned to the health center. This calculation yielded planned visits per capita. For all categories except outpatient visits, a

second calculation was made to convert the per capita statistic to reflect the anticipated demand for that service. These conversions were made as follows:

- Family planning visits per woman of reproductive age – family planning visits per capita divided by the percent of the Salvadoran population that are women of reproductive age (.317[2])
- Deliveries per 1,000 population – deliveries per capita multiplied by 1000
- Prenatal visits per birth – family planning visits per capita multiplied by 1000 and divided by the Crude Birth Rate for El Salvador (27 per 1000 population[3])
- Pentavalente applications per birth – pentavalente visits per capita multiplied by 1000 and divided by the Crude Birth Rate for El Salvador (27 per 1000 population[4])

Family planning targets do not link to population needs, as Figure 3 illustrates. Although the median health center achieved 90 percent of its goal, the goal translates to only 0.16 family planning visits *per year* per woman of reproductive age.

Figure 3: Family Planning Visits per Woman of Reproductive Age

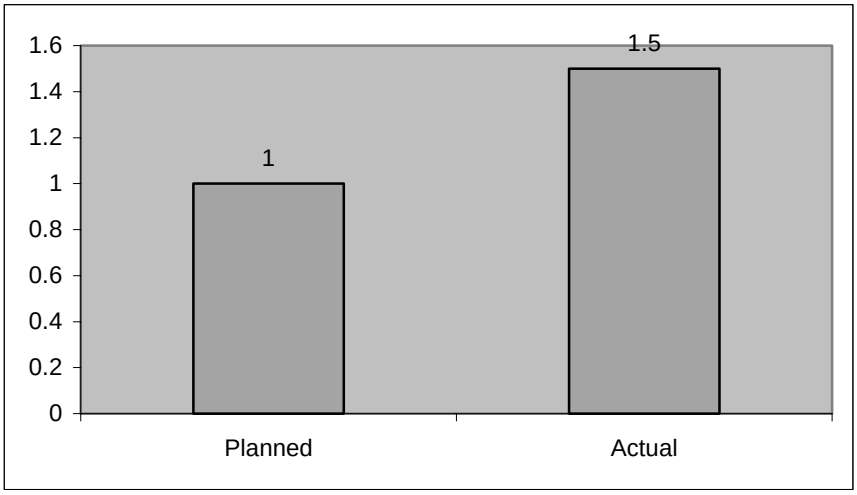


Of that goal of 0.16 visits, the median facility provided only 0.14. Because targets are not based on population responsibilities, these targets varied widely across facilities. One-quarter of facilities reported targets to provide fewer than 0.08 visits per woman (but they do cover 100 percent of that goal), and another 25 percent of facilities plan three times as many visits with targets of more than 0.29 visits per woman of reproductive age.

[2] Calculated from Sistemas Básicos de Salud Integral (SIBASI): Según Caracterización Sociodemográfica 2001.
[3] National Family Health Survey (*Encuesta Nacional de Salud Familiar* [FESAL]-98)
[4] FESAL-98

The current methodology used to set targets can lead to misrepresentation of a health center's actual achievements. For the case of outpatient visits, a typical health center covers 150 percent of its planned outpatient visits (Figure 4). Although the facility is greatly exceeding its goal, this statistic does not indicate the level of demand met by the facility.

Figure 4: Outpatient Visits per Inhabitant

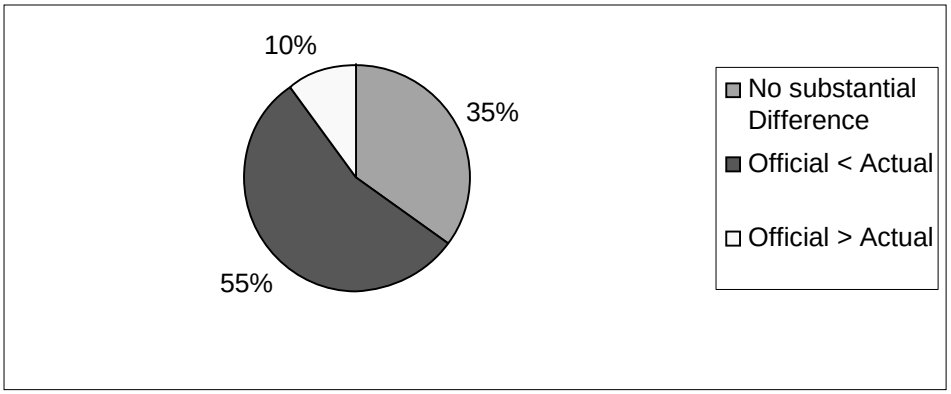


Although the typical facility plans one outpatient visit and provides 1.5 visits per inhabitant, utilization at most health centers varies widely: 25 percent of health centers plan fewer than 0.75 visits and provide 1.1 visits per inhabitant. Another 25 percent plan more than 2.2 visits and provide more than 1.9 visits per inhabitant. These large disparities demonstrate that some health centers receive targets three times larger than similar facilities with the same population responsibilities.

Despite the challenge of not having accurate population-based data, health center directors can estimate their catchment population with a certain amount of precision. Because the fundamental principle of the MSPAS system is that each family is the responsibility of one specific health center, this assessment asked facility directors how many individuals lived in their facility's catchment area and how many of those were of immunizable age. Because the last Salvadoran census was conducted in 1992, the directors were also asked to estimate the difference between their assigned, official population used for planning and the actual population living in the catchment area. All health centers could state their official population and provide an estimate of the number of children of immunizable age. This local knowledge should be tapped when setting service delivery targets by population health needs.

In addition to ascertaining whether the facility directors could state their official population responsibility, the interviewers asked directors if this official population differed substantially from their estimate of the actual number of inhabitants. Figure 5 indicates that 35 percent of health center directors felt that their official population accurately represented the number of individuals living in the geographic area. An additional 55 percent stated they had more and 10 percent had less than the official population. The average facility reported a 20 percent absolute difference between their actual and official population.

Figure 5: Official Population Compared to Estimated Actual Population



These population differences can greatly limit the value of planning targets and calculated coverages. For example, if a facility successfully provides sufficient vaccinations to meet its planned goal, 20 percent of children can remain unvaccinated if the figure used for planning differs from the actual population by that amount. The fact that the median facility currently exceeds its planned vaccinations by 20 percent may be a sign that incorrect population statistics are used for planning.

Until a new census is planned, an interim measure may be used to update official population figures: the Salvadoran Demographic Institute can assess the potential of using the 2002 FESAL (DHS) to produce more accurate population estimates based on the latest large household survey.

Finding #4: Coverage targets do not reflect national protocols.

Because service provision targets are not based on population demand, coverage targets do not correspond to the service protocols issued by MSPAS. Figures 6 and 7 illustrate this challenge for both prenatal visits and pentavalente applications. Figure 6 indicates that the typical facility plans only 4.4 prenatal visits per birth (in contrast to the MSPAS norm of 6.0), and actually provides 2.7 visits per birth. Similarly, Figure 7 indicates that the same health center plans only 1.9 pentavalente applications per birth (compared with the MSPAS norm of three vaccinations in the first year of life), and actually provides 2.1. It should be noted that those 2.1 applications translate to a 110 percent coverage of the facility's planned pentavalente vaccinations.

Figure 6: Prenatal Visits per Birth

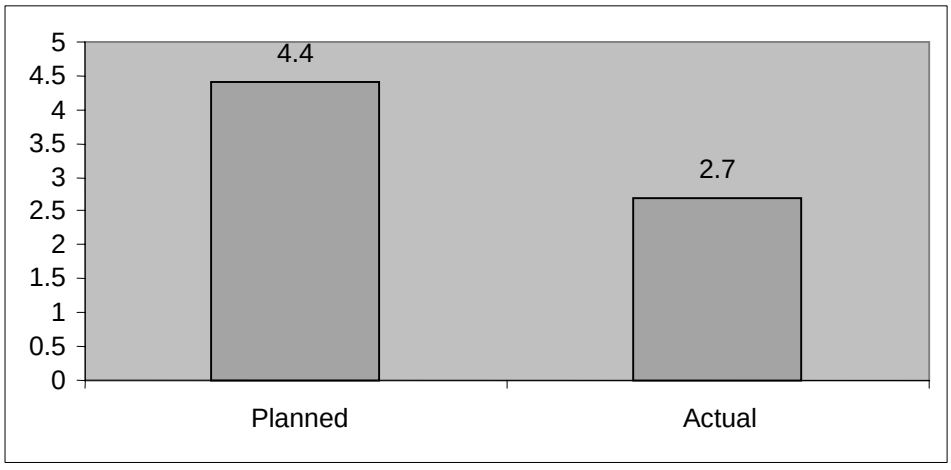
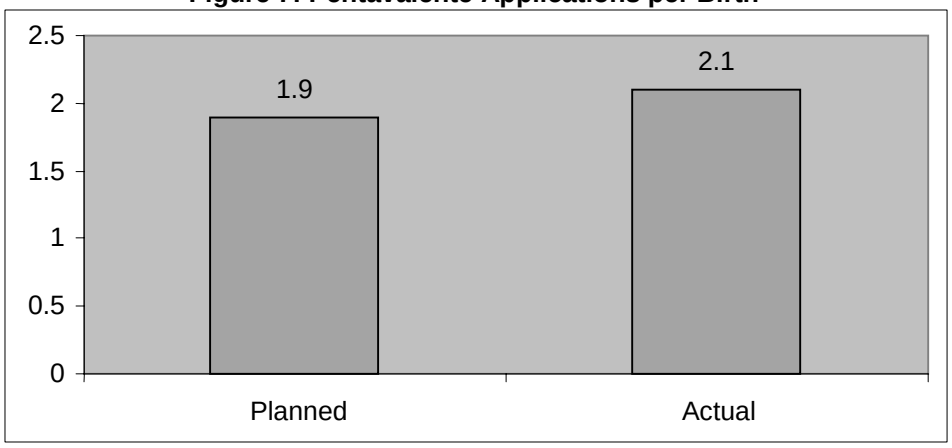


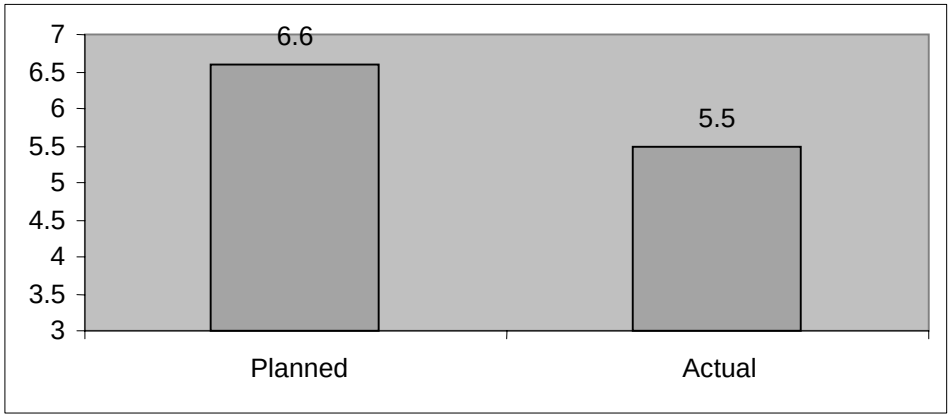
Figure 7: Pentavalente Applications per Birth



Finding #5: Further integration is needed between planning targets for health centers and hospitals.

A final planning challenge stems from the lack of integration between hospital and primary care facilities' annual plans. The case of planned deliveries, as shown in Figure 8, illustrates this point. The typical health center plans to attend 6.6 births per 1000 population and actually attends 5.5 deliveries. Similarly, the average hospital plans to attend 26 births per 1000 population.[5] These two values contrast with the national crude birth rate of 27 per 1000. Since the median primary care provider is planning for only 26 percent of the likely births in its population and the average hospital in these SIBASIs is planning for 96 percent of expected births, there is an obvious need for improved communication between primary care providers and hospitals during their annual planning activities.

Figure 8: Health Center and Midwife Deliveries per 1,000 Inhabitants



[5] Only three of the four hospitals interviewed provided a value for planned births. The three values were 40, 13, and 26 for an average of 26 births per 1000 population.

4.3 Management

4.3.1 Overview of Management

The new management structures of the SIBASI are the direct results of the SIBASI reforms. SIBASIs have already gained substantial experience with their management committees, but they have also encountered challenges that were unforeseen during the conceptual development of the SIBASI model. The following paragraphs provide observations on the management structure.

Achievements:

- All SIBASIs have directors and functioning management committees in place.
- SIBASI health center leaders perform some key management functions.
- New SIBASI management demonstrates initiative and leadership.

Challenges:

- There is an over reliance on medical students in management positions.
- The roles and responsibilities are unclear.
- There is minimal participation of non-MSPAS representatives on the SIBASI management committee.

4.3.2 Description from SIBASI Administrative Manual on Management

The administrative structures of the SIBASI represent a fundamental change from the previous departmental management structure. The new administrative structure calls for participatory management from three separate entities:

- Permanent SIBASI headquarters staff
- A management committee composed of representatives from all health providers in the SIBASI (MSPAS and non-MSPAS)
- A social oversight committee

4.3.3 Key Findings on Management

Finding #1: All SIBASIs have directors and functioning management committees in place.

In May 2002, six of the seven SIBASIs in the assessment had permanent directors and the seventh operated with an interim director. Directors of the larger SIBASIs frequently had been directors in one of the previous department administrations, but the directors for the outlying SIBASIs had varying experiences in health management. In multiple cases, the hospital director in the new SIBASI was appointed to lead the SIBASI in addition to maintaining his responsibilities at the hospital. In other cases, a senior director from a health center was promoted to lead the new SIBASI.

The creation of the new management committees has proved to be a key development in the implementation of the SIBASI model, with functioning management committees active in each of these seven SIBASIs. In every case, the management committee meets either weekly or biweekly for half- or full-day meetings. Although the organization of the committees varies, these management committees have served as a common forum for solving problems facing the SIBASIs. This joint problem solving has produced the following three results: increased initiative and ownership of problems by MSPAS staff, a greater understanding on the part of SIBASI staff of the challenges facing MSPAS, and a new cooperation between primary and secondary care providers.

The average management committee has 15 members. These members generally consist of three to four representatives from the hospital, the SIBASI director, several members of the SIBASI technical team, and representatives from the health centers. In some instances, SIBASIs have extended membership to include representatives of MSPAS providers based in the community (health promoters, inspectors). The most substantial difference from previous management committees is how the health units are represented on the committee. The smallest SIBASI includes one representative per establishment. In SIBASIs with more establishments, this model for representation produces large committees (of more than 20) that have proved ponderous. An alternative structure utilized by large SIBASIs has been the creation of three to four networks of health centers within the SIBASI. Each network then selects two representatives sit on the management committee. One of these representatives is a doctor and the second a nurse, providing more diversity in representation and professional perspective. For SIBASIs with networks, each network has its own formal or informal management committee composed of representatives from each establishment. These network management committees operate in a manner similar to the SIBASI-wide committee.

Finding #2: SIBASI health center leaders perform some key management functions.

As the management committees began their tenure, health center directors were already performing some key management functions at their facilities. Table 2 displays the percentage of health centers implementing key management practices.

Table 2: Facility-Specific Management Structures

Facility holds periodic administrative staff meetings	98%
Facility keeps minutes at those meetings	74%
Facility reported having a formal quality assurance system	25%
Facility conducts reviews of near-miss maternal and newborn deaths	90%
Facility reported having confidentiality protocol for STI* clients	41%
Facility has established procedure for transporting obstetric emergencies	73%

* STI = Sexually Transmitted Disease

As a group, primary care facilities conduct facility administrative staff meetings, and 74 percent maintain minutes from those meetings.

Organized clinical oversight proved less common with only 25 percent of facilities stating that they had a formal quality assurance system. This does not represent the number of facilities that conduct some form of internal quality assurance. When asked whether they conduct reviews of near-miss maternal and newborn deaths, 90 percent responded in the affirmative. Primary care facilities do have individual components, but a formal, organized quality assurance system does not exist in 75 percent of the facilities interviewed.

The presence of program-specific policies also varies widely across facilities within each SIBASI. As a group, only 41 percent[6] reported having a confidentiality protocol for STI clients. Similarly, 73 percent of establishments have a formalized procedure for transporting obstetric emergencies to the referral facility.

Finding #3: New SIBASI management demonstrates initiative and leadership.

The new participation of headquarters and facility staff in decision making has led to staff initiative not present in the previous administrative model. During the initial data collection, staff repeatedly volunteered that SIBASI personnel and facility directors are demonstrating a new ownership of MSPAS problems. They explained that the previous administrative model discouraged initiative and most staff would simply report a problem and wait for their directors or supervisors to present solutions. Through their experience on the management committee, more staff have begun to take a personal interest in MSPAS problems. Multiple examples were discussed, ranging from the sense of personal responsibility staff felt when signing their name to management committee agreements, to using personal funds to guarantee payment of health center obligations.

In addition to imbuing a new problem-solving approach on the part of SIBASI staff, the management committee has become able to view an individual facility's difficulties in the broader SIBASI perspective. SIBASI leaders reported that facility directors' participation on the management committee has increased awareness of the problems facing all facilities. Although the facility director is responsible for representing his establishment's interests on the committee, deciding how to address the problems of all facilities has allowed individual directors to see their own difficulties within a broader perspective.

The new SIBASI management committee has produced a new level of cooperation and integration between primary and secondary care providers. This integration of the hospitals and health centers has resulted in an improved referral/counter-referral system between primary and secondary care and this cooperation has continued. For clinical services, hospitals have offered refresher training to primary care staff while primary care facilities have opened on weekends to reduce the demand placed upon the hospital's emergency room. This cooperation has also expanded to nonclinical support, as multiple hospitals have assigned their maintenance staff to repair primary care and SIBASI headquarters facilities.

Despite achievements in a remarkably short time period, many challenges remain. The remaining findings prioritize obstacles SIBASI directors will have to overcome before they can realize their full potential as SIBASI management. Challenges are explained in order of priority.

Finding #4: SIBASI administrative teams are not fully staffed due to imbalance in staffing allocations.

The number of staff on each SIBASI's technical team does not correspond with population size and number of facilities within the SIBASI's geographic area. Although each SIBASI has an administration in place, the number of staff assigned to the SIBASI administration varied. In its conceptual form, the SIBASI administrative manual outlines a SIBASI administration composed of the director, a three-person technical team, and a five-person administrative team. The actual number of individuals in each SIBASI administration ranges from as few as four to as many as 25 and 30.

The general determinant of the size of a SIBASI administration has been its location relative to the old department office. If a department had a single hospital, then that department was converted to a single SIBASI that inherited all staff from the department's administration. These SIBASIs have large

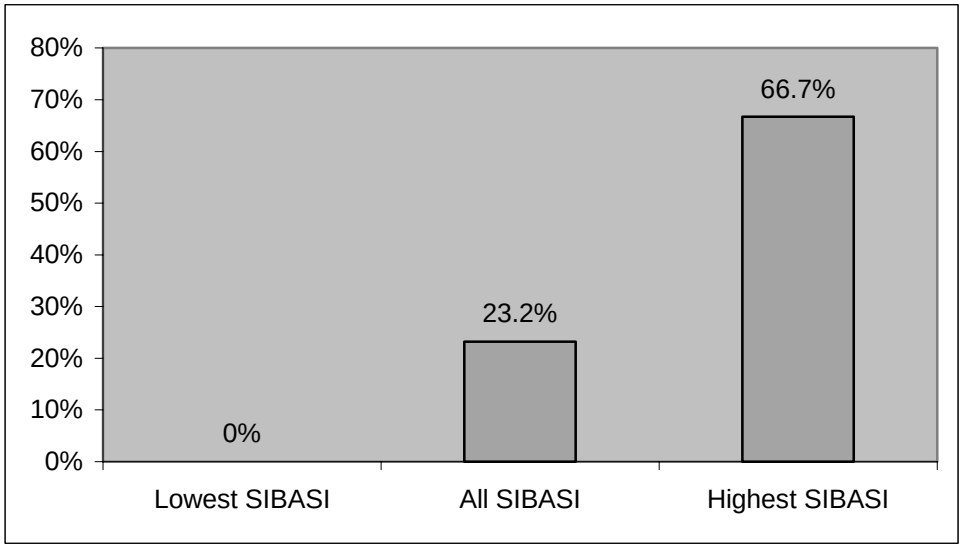
[6] Of those reporting that they did have a protocol, 39 percent could not produce a copy of the policy.

technical and administrative teams. If a department had multiple hospitals and was subdivided to form multiple SIBASIs, the SIBASI based in the old department offices retained all administrative staff with only an occasional individual reassigned to the second (or third) outlying SIBASI in the department. These outlying SIBASIs typically have three to seven staff on the technical team and no staff for their administrative team. All administrative functions remain with the SIBASI that inherited the department administrative offices and staff.

Finding #5: There is an over-reliance on medical students in management positions.

A major challenge for SIBASI management is the high number of facility directors who are completing their year of public service and are transitory members of the management committee. Figure 9 indicates reliance on one-year public service appointments of recent medical school graduates of SIBASIs studied: nearly one quarter (23.2 percent) of all health centers in these SIBASIs are led by a public service medical graduate. The magnitude of the problem varies from SIBASI to SIBASI: Reliance on medical students is not a problem for the SIBASIs closest to San Salvador, which have no health centers being led by medical graduate students. This problem escalates, however, in the SIBASIs farthest from the capital, the most extreme case being one SIBASI in the east that has 67 percent of its health centers led by public service physicians. Public service staff are unlikely to serve on the management committee if permanent staff are available.

Figure 9: Percent of Health Centers Led by a Public Service Medical Graduate



When the public service appointments expire in December, these eastern SIBASIs will face a large, simultaneous turnover of many committee seats. Since no SIBASI management committees have been operating for more than 12 months, the impact of this simultaneous turnover on the committee's operations remains unknown. Depending upon the personalities involved, the more senior members (many being the director, technical team, and hospital staff) could act as a stabilizing influence or lead to a potentially disproportionate amount of influence for those more senior members.

Finding #6: The roles and responsibilities are unclear.

As the SIBASI model has moved to full implementation, the SIBASI managers have found that their roles and responsibilities were not clearly defined in the administrative manual. The lack of clarity in the division of responsibilities between the SIBASI director and management committee, as well as between the SIBASI and zone technical teams, has produced the most immediate challenges.

The relationship between the SIBASI director and the management committee remains an unresolved problem. In the administrative handbook distributed to the SIBASI, the management committee and the SIBASI director share the same box on the organizational chart, with the committee placed above the director. Two interpretations exist among SIBASI managers on this relationship. In most cases, the management committee is seen as a common forum and consultative body to address problems facing the SIBASI, but the director retains practical control. Some SIBASIs, however, have a different interpretation of the organizational diagram in the administrative manual. They see the management committee as the decision-making body for the SIBASI, and the director as the person who implements plans and decisions made by the committee. Multiple SIBASIs expressed a desire for more information and clarity on how the Ministry envisioned this relationship.

In addition to their relationship in the hierarchy, the SIBASI director and the management committee face another challenge to their relationship on a day-to-day basis. Since many requests from the Ministry and zone technical teams require immediate attention and the management committee meets only once every seven to 15 days, the SIBASI director retains most of the practical authority. The management committee is unlikely to be meeting when the Ministry or zone requires a decision, and, therefore, it is the SIBASI director who retains the actual decision-making authority.

In addition to the SIBASI lacking a formal legal status, the roles and responsibilities of the ETZs remain unclear. The purpose of the ETZ, as described in the SIBASI manual, is to serve as a resource and interface between the SIBASI and the Ministry. Although multiple SIBASI directors volunteered that the ETZ legal advisors had proved invaluable, a general consensus exists that the larger ETZs as a whole had yet to serve as real resources for the SIBASI. The directors stated that some members of the ETZs remain uncertain of their new roles and continue to conduct the same supervisory visits that were their responsibility in their previous positions at the department level. Much of this overlap in roles and responsibilities between the ETZs and SIBASIs stems from the fact that the SIBASIs did not exist as legal entities as of May 2002 when this assessment began.

Finding #7: There is minimal participation of non-MSPAS representatives on the SIBASI management committee.

Although the management committee will eventually include representatives from all providers active in the SIBASI, membership is currently limited to MSPAS personnel. Some committees consult frequently or work closely with the Social Security Institute or a local nongovernmental organization (NGO), but these organizations are not offered formal membership on the management committee.

The SIBASIs are aware of the need to include the non-MSPAS entities in the decision-making body, but for now they prefer to proceed cautiously. The current focus remains on experimentation and learning the internal dynamics of the management committee. The committee now acts as a forum where MSPAS staff openly criticize themselves and each other. This open criticism has been a new experience for many, and remains uncomfortable for most. SIBASI leaders commonly believe that including non-MSPAS providers holds considerable potential, but also substantial risk at this stage of development. Any group brought into the committee could both observe and contribute to the criticism among MSPAS staff, but these new members would also need to be prepared for criticism towards their own establishments and

organizations. Current SIBASI leaders plan to include non-MSPAS providers only after understanding the best manner to manage internal criticism among their own MSPAS providers.

4.4 Finance

4.4.1 Overview of Finance

The SIBASIs began with some financial oversight mechanisms inherited from the departments, but the SIBASIs also were given ample room to improve efficiency in resource utilization. The following offers an overview of key findings regarding SIBASI finances:

- There is some capacity at the SIBASI level to administer finances.
- A large percentage of salaries are dedicated to community-based providers.
- There is an imbalance in the allocation of salaries.

4.4.2 Description from SIBASI Administrative Manual on Finance

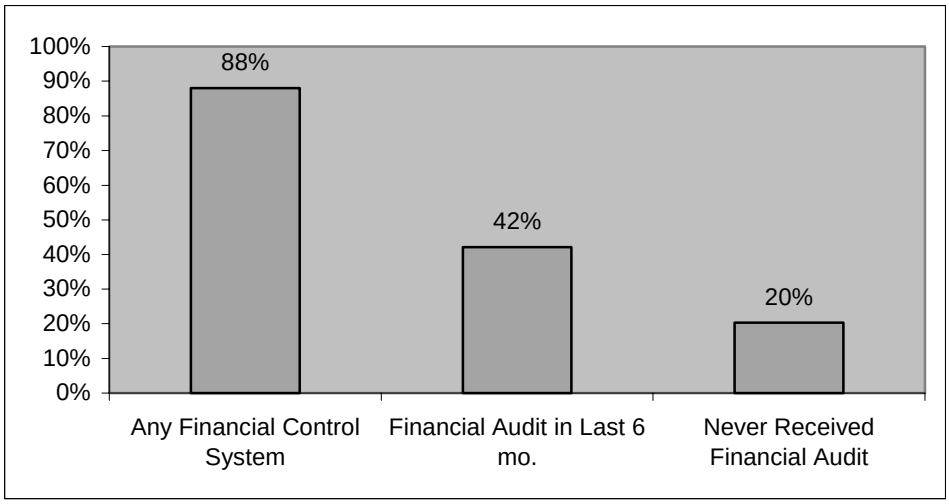
The SIBASI financial system is responsible for preparing the SIBASI budget, tracking and analyzing SIBASI expenditures, and acting as its business office to review, authorize, and pay the SIBASI expenditures.

4.4.3 Key Findings on Finance

Finding #1: There is some capacity at the SIBASI level to administer finances.

The SIBASIs began with some accounting and oversight systems already in place at their health centers. Most facilities retained the vestiges of the financial control system that existed before the elimination of cost recovery (*fondos propios*) in June of 2002. Figure 10 indicates that 88 percent of facilities reported having some form of financial control system. In its simplest form, this consisted of the checkbook register for an account at a local bank. Other facilities used double signatories and some bookkeeping. Additionally, almost one-half of facilities could expect their records to be audited in a six-month period. Only 20 percent of facilities had not been audited in the previous 12 months.

Figure 10: Accounting Oversight Practiced at Facilities



Most administrative capacity remains with the SIBASIs located in offices previously used by the department, unless the SIBASI director doubles as the hospital director and can draft the administrative personnel of the hospital. If a department was subdivided to form multiple SIBASIs, the SIBASI based in the old department offices retained all administrative staff with only an occasional individual being reassigned to the second (or third) outlying SIBASI. If they did not inherit administrative staff from the department, then these outlying SIBASIs lack financial personnel. Only when the hospital director doubles as the SIBASI director do these SIBASIs possess financial oversight resources. In these cases, the SIBASI director co-opts his hospital staff to manage the SIBASI accounts.

In May of 2002, the SIBASIs did not produce or manage their own budgets. Explicit SIBASI budgets did not exist, and all 2002 expenditures were based on the department model. If a single SIBASI occupies an entire department, the department budget effectively belongs to the SIBASI. In multiple SIBASI departments, the SIBASI occupying the department offices manages the old department's budget for itself and the new SIBASI(s) in the department. These department offices can and do track SIBASI expenditures, but midyear financial reports are not possible.

Department administrators can identify expenditures to date, but the current system prevents their identifying the budget remaining for the rest of the year. With all financial resources remaining under control of the Ministry, midyear shifts between accounts are common. These shifts prevent a SIBASI director from determining the resources remaining to his organization.

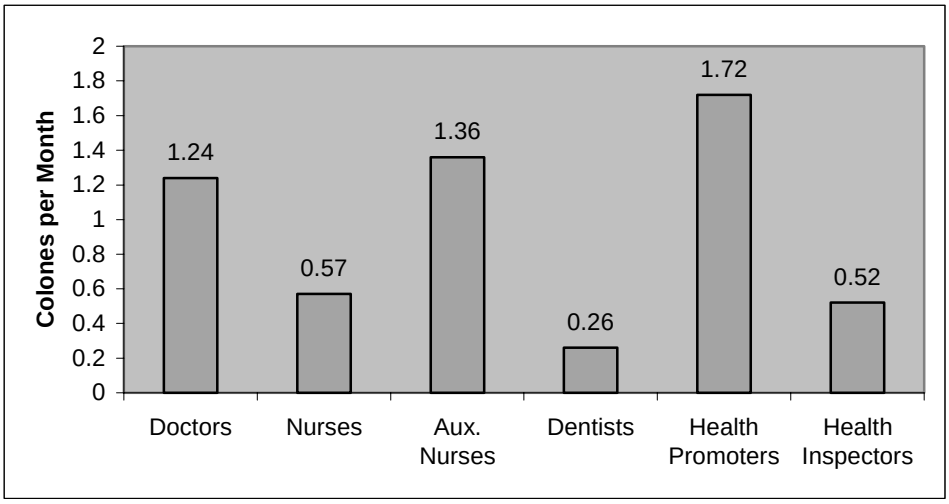
Finding #2: A large percentage of salaries are dedicated to community-based providers.

Since the majority (70 percent)[7] of MSPAS funds are dedicated to salaries, this assessment can estimate financial expenditures currently dedicated to each SIBASI. Based on this 70 percent, the assessment identified the total number of each type of clinical staff available (doctors, nurses, dentists) at each facility. Subsequently, the number of staff in each category was multiplied by the average wage paid for that staff category (a complete description of the methodology can be found in the annex). These were then combined with the facility's population responsibility to estimate average salary expenditures on doctors, nurses, nurse auxiliaries, dentists, health promoters, and health inspectors paid directly by MSPAS per 1,000 population in that area. These salary expenditures exclude staff not paid by the Ministry (any staff contracted through locally provided funds).

Based on staff availability, the assessment determined how salary expenditures are distributed across different health cadres. Figure 11 indicates that on average, the Ministry pays 5.7 colones[8] per month in clinical salaries for each inhabitant served within one of its health centers. Salary expenditures per inhabitant varied widely across SIBASIs, however, with the lowest SIBASI averaging 4.2 colones per month and the highest SIBASI averaging 8.1 colones per month.

[7] Cuentas Nacionales en Salud 1998.
[8] 8.75 colones = 1 US$

Figure 11: Facility Salary Expenditures Paid by Ministry Funds

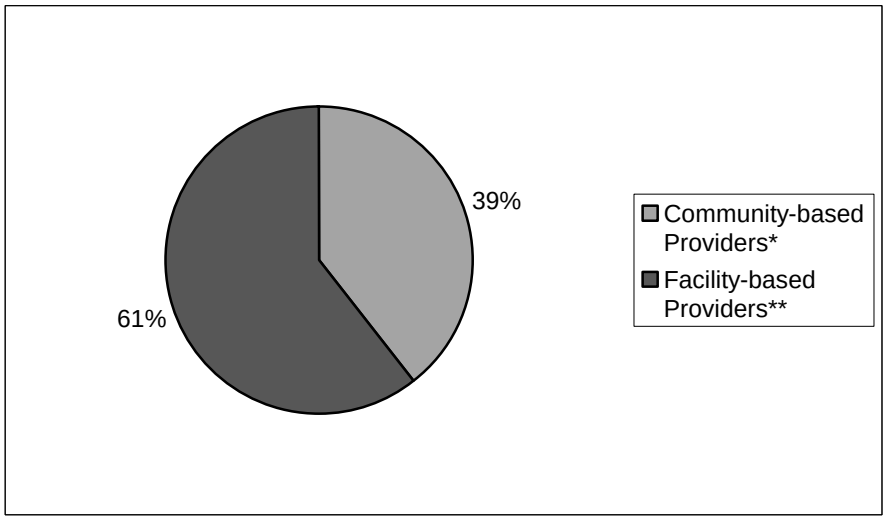


*8.75 colones = 1 $US

To provide care for the average individual, the Ministry dedicates its largest salary expenditure of 1.7 colones per month for health promoters, followed by 1.36 colones for auxiliary nurses and 1.2 colones for doctors. Nurses, dentists, and health inspectors claim smaller budget allotments, with 0.6, 0.3, and 0.5 colones per month, respectively, spent on salaries.

The salary expenditure estimates demonstrate that a large percentage of salaries are allocated to community-based providers. Figure 12 indicates that 61 percent of health center salaries are spent on facility-based providers and the remaining 39 percent are allocated to community-based providers. As mentioned previously, the Ministry spends 5.7 colones each month per inhabitant to support health center clinical staff. Of that 5.7 colones, 2.2 (39 percent) is spent on health promoters and health inspectors working in the community and 3.5 colones are spent for doctors, nurses, nurse auxiliaries, and dentists working at the facility.

Figure 12: Ministry Salaries Dedicated to Facility- vs. Community-Based Providers



*Community-based providers are health promoters and inspectors for this calculation.
**Facility-based providers are doctors, dentists, nurses, and nurse auxiliaries for this calculation.

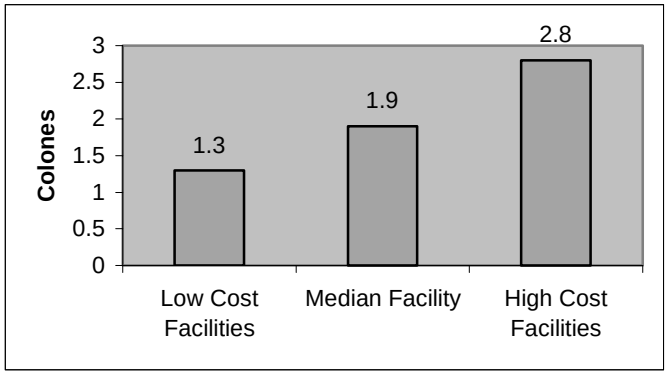
This substantial portion of salary expenditures dedicated to community-based providers reflects consistency with the SIBASI emphasis on accessible, priority health services. In the previous department management model, community-based providers often proved an underutilized resource. As the SIBASI develop, it will be imperative to integrate facility- and community-based providers to maximize the benefit to the population from this salary category.

Finding #3: There is an imbalance in the allocation of salaries.

Combining the Ministry salary expenditures in Figure 12 with the outpatient visits provided by the health centers allows the estimation of the productivity of salary costs to the Ministry for a given level of demand. It should be noted that these estimates are not total salary costs per outpatient visit, because they exclude the costs of salaries for staff contracted locally.

Figure 13 ranks all health centers from lowest to highest MSPAS salary cost per outpatient visit. At a typical health center in these SIBASIs, the Ministry pays 1.9 colones in facility-based salaries (doctors, nurses, auxiliary nurses, and dentists) per outpatient visit.

Figure 13: Ministry Salary Support per Facility Visit



*8.75 colones = 1 $US

Although the median facility provides a facility visit for 1.9 colones in salaries, many facilities requires substantially more per visit while others requires considerably less. High-cost facilities[9] require 2.8 colones in Ministry salaries per visit while the low-cost facilities[10] provide visits for 1.3 colones in salaries.

This variation in cost and efficiency stems from several sources. First, many health centers are supported from local funds while others remain more dependent upon Ministry salaries. Secondly, MSPAS utilizes a standard staffing pattern for smaller clinics, independent of the demand in the area and of patient loads. This standard staffing creates situations where a clinic serving a community of 3,000 inhabitants enjoys the same staffing as a clinic serving 8,000 inhabitants. To increase efficiency, the SIBASI will need to identify creative mechanisms to better utilize scarce staff resources in low utilization settings.

[9] The 75th percentile facility for salary expenditures per outpatient visit.
[10] The 25th percentile facility for salary expenditures per outpatient visit.

4.5 Regulation

4.5.1 Overview of Regulation

The transition of the regulatory framework to the new SIBASI model has begun, but much work remains. The following are key findings regarding the regulatory framework:

- MSPAS has started the process of updating protocols in support of the SIBASI integrated health care model.
- There is limited access and therefore limited use of new children and women's health protocols.

4.5.2 Description from SIBASI Administrative Manual on Regulation

As conceived in the administrative manual, the SIBASI regulatory system is responsible for implementing rules, norms, and protocols developed by the Ministry.

4.5.3 Key Findings on Regulation

Finding #1: MSPAS has started the process of updating protocols in support of the SIBASI integrated health care model.

As the SIBASIs began implementation, the Ministry simultaneously advanced the preparation of the new clinical protocols and regulations based on the SIBASI integrated care model. As the reforms progress, the Ministry plans to prepare and distribute new protocols for each of the six categories of medical attention outlined in the integrated care model:

1. Integrated child health care
2. Integrated adolescent health care
3. Integrated women's health
4. Integrated adult male health
5. Integrated gerontology (*salud del adulto mayor*)
6. Integrated environmental health

When the survey team began the facility interviews, the Ministry reported that two of the six new protocols were completed: integrated child health care and integrated women's health care. The survey team ascertained which protocols the facility was utilizing for children and women's health, and when the facility could present a set of protocols, the name and date of the document were recorded.

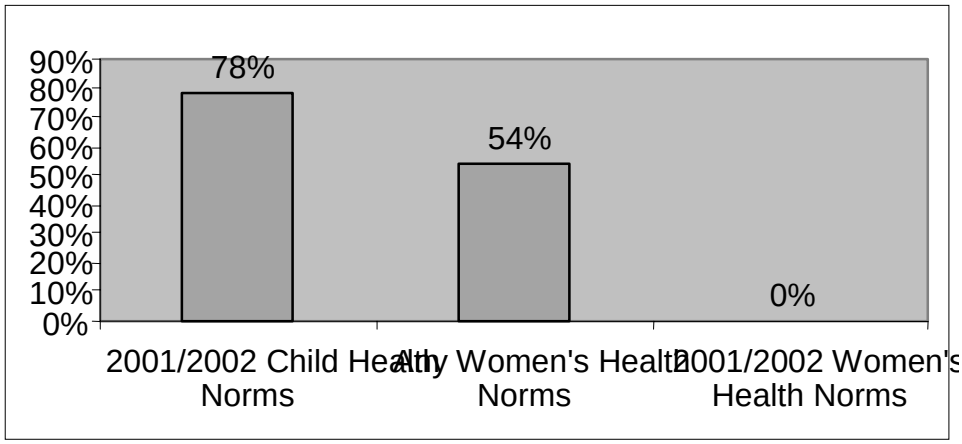
Finding #2: There is limited access and therefore limited use of new children and women's health protocols.

Even though MSPAS has widely disseminated new protocols for children and women's health, the surveyed health centers reported limited access and use of these new protocols, as indicated in Figure 14. The Ministry has successfully disseminated the new child health norms (*Atención Integral a los Menores*

de Cinco Años, AIEPI) to most health centers, with 78 percent of facilities able to produce a 2002 or 2001 (66 percent and 12 percent, respectively) dated manual during the interview.

Health centers had yet to receive new protocols for women's health when the facility interviews began in July 2002. Furthermore, many of the health centers failed to produce any protocols for women's health, with only 54 percent of facilities able to produce a copy of any set of women's health protocols. None of the protocols at the facilities corresponded to the new SIBASI integrated care model since all protocols were dated 1999 or earlier (excluding two family planning manuals from 2000). Excluding a few older manuals, facilities are operating with *Atención a la Persona* 1999 as their current norm for women's health.

Figure 14: Presence of New SIBASI Children and Women's Health Protocols



4.6 Health Information System

4.6.1 Overview on Health Information System

The SIBASI has an extensive health information system (HIS) in place, but obstacles must be overcome before it can achieve its full potential. Key findings about the HIS are as follows:

- All SIBASIs have a functioning and standardized HIS in place, but the focus of data collected has not shifted to the SIBASI model of integrated care.
- Almost all health centers track and report common preventive care visits and disease incidences.
- The quality of data collected by the HIS is weak.
- Data collected for the HIS are not utilized to their full potential.

4.6.2 SIBASI Administrative Manual Description on HIS

The SIBASI HIS is responsible for the following:

1. Administration and maintenance of computer systems

2. Data collection, processing, and dissemination

The first responsibility – the administration and maintenance of computer systems – requires the HIS to develop a SIBASI-wide computer technology plan, implement the plan, and finally, administer and maintain the computers involved in the technology plan. The second responsibility – data collection, processing, and dissemination – requires the HIS to collect, validate, analyze, and disseminate the data from the SIBASI HIS.

The assessment focused on the second responsibility. The first was excluded because most SIBASIs have very few (two or three) older computers and, excluding one SIBASI, computers are currently rare in health centers.

4.6.3 Key Findings on HIS

Finding #1: All SIBASIs have a functioning and standardized HIS in place, but the focus of data collected has not shifted to the SIBASI model of integrated care.

The HIS function has effectively been decentralized from departments to SIBASIs. All SIBASIs have a functioning, standardized HIS system inherited from the departments. The SIBASIs have assumed responsibility for the system, are processing information at the SIBASI level, and have been able to expand the scope of HIS to include non-MSPAS health data. Although various kinds of data are being collected at the SIBASI level, the focus of data collection has not shifted to the SIBASI model and its information needs.

At the core of the system, each facility utilizes a set of registers distributed by the Ministry to track utilization and service provision on a daily basis by type of visit and program. At the end of each month, these daily registers are aggregated to produce a facility-wide register. Similarly to the health centers, health promoters, midwives, and health posts maintain their own registers of epidemiological and service provision statistics. Each month these registers are physically brought to their associated health center, where they are added to the facility's statistics. If the establishment has a computer, all data are digitized at the facility; otherwise, the paper reports are delivered to the SIBASI offices, which digitize and aggregate the data to produce SIBASI-wide epidemiological and service provision reports. The SIBASI submits the electronic data and an overview report to the Ministry.

Every three months, the HIS and the monthly overview reports are aggregated to produce a quarterly evaluation to measure the performance of each health center. From these reports, SIBASI staff evaluate the performance of each health center against its coverage targets in its annual operating plan. SIBASI staff subsequently meet with facility personnel to discuss the health center's performance. Through these quarterly evaluations, the HIS currently acts as the main instrument for facility monitoring and evaluation for the SIBASI.

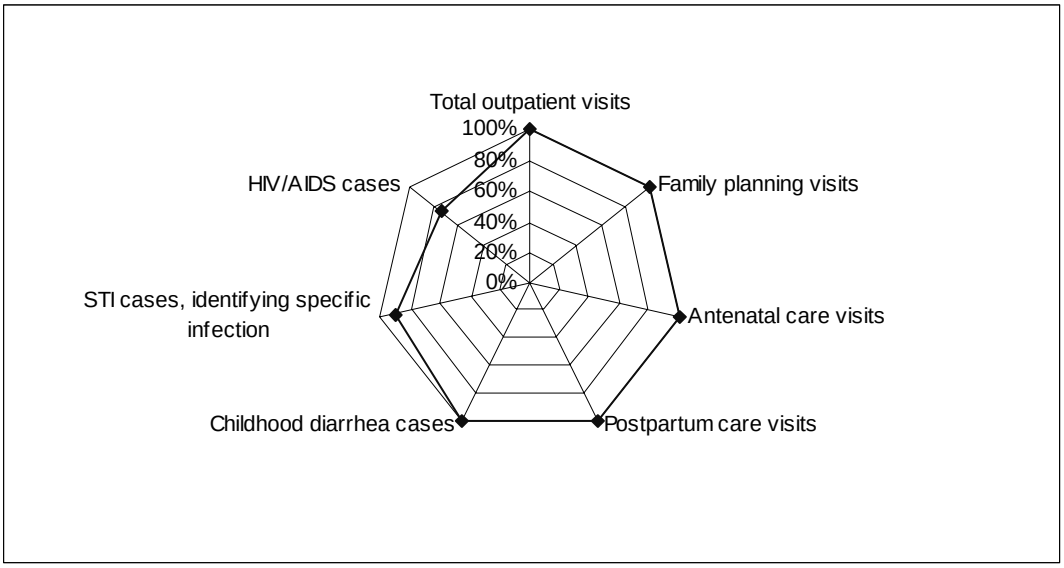
Some SIBASIs are making an effort to include data from non-MSPASs providers, as proposed by the SIBASI model, but participation by non-MSPAS providers varies by SIBASI. Social Security providers routinely contribute only their disease incidence and vaccination information. Military providers typically limit their data to disease incidence. Private providers contribute data to the SIBASI HIS only on a very

limited basis. NGO participation depends upon the SIBASI's initiative to build relationships with NGO providers. A limited number of NGOs currently contribute vaccination data, but SIBASIs with more developed social participation have reported greater success at encouraging NGOs to participate in the SIBASI HIS.

Finding #2: Almost all health centers track and report common preventive care visits and disease cases.

Almost all health centers track and report common preventive care visits. All health centers currently track and report on antenatal, postpartum, family planning, and total outpatient visits. Figure 15 displays the percent of facilities recording utilization statistics and disease cases for a sample of visit types and diseases.

Figure 15: Facilities Tracking Specific Utilization and Disease Cases

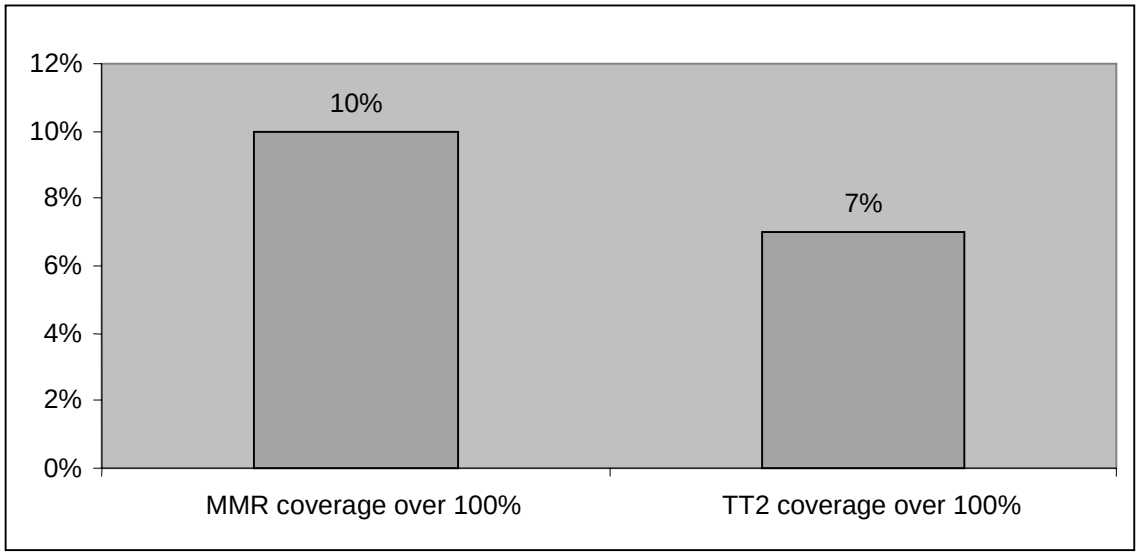


Health centers also report and track incidence of diseases through an elaborate epidemiological monitoring system. The system proved too broad to evaluate within the scope of this assessment. The interviewers sampled statistics for only three key disease categories: childhood diarrhea, STIs, and HIV/AIDS. Of these categories, all facilities track cases of childhood diarrhea. Most (90 percent) track STIs by the specific infection and relatedly track HIV/AIDS (74 percent). It should be noted that HIV/AIDS was rarely tracked independently, but instead is treated as a general STI visit in the aggregate facility totals.

Finding #3: The quality of data collected by the HIS is weak.

The quality of the data collected is a concern. The section on planning highlighted some of the methodological problems that occur as a result of how MSPAS sets targets. An example is vaccine coverage rates; the survey considered coverage for two vaccinations: measles, mumps, rubella (MMR) and tetanus toxoid. Figure 16 indicates that 10 percent of health centers reported MMR coverage rates over 100 percent, while 7 percent reported tetanus toxoid coverage over 100 percent. Understanding and improving the HIS will be essential if SIBASI and facility directors are to be able to use these data for management decisions.

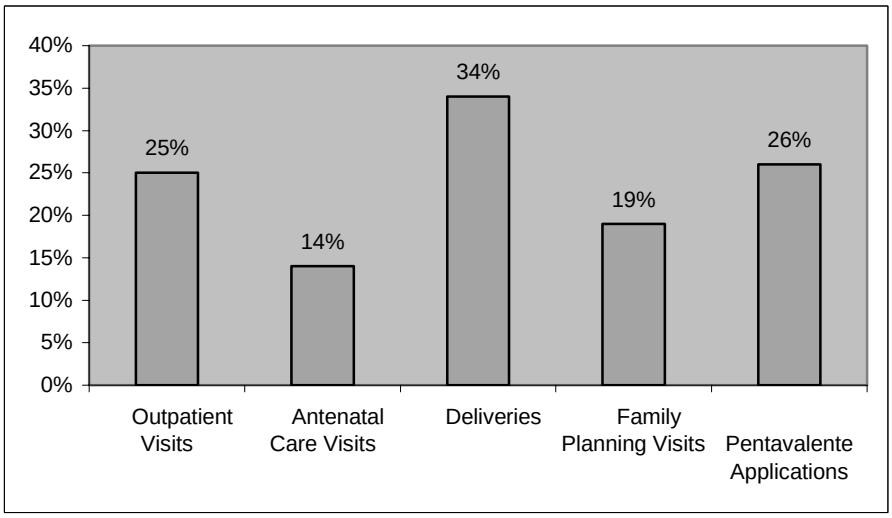
Figure 16: Data Quality: Example of Vaccine Coverage Rates over 100 Percent 100%



Finding #4: Data collected for the HIS are not utilized to their full potential.

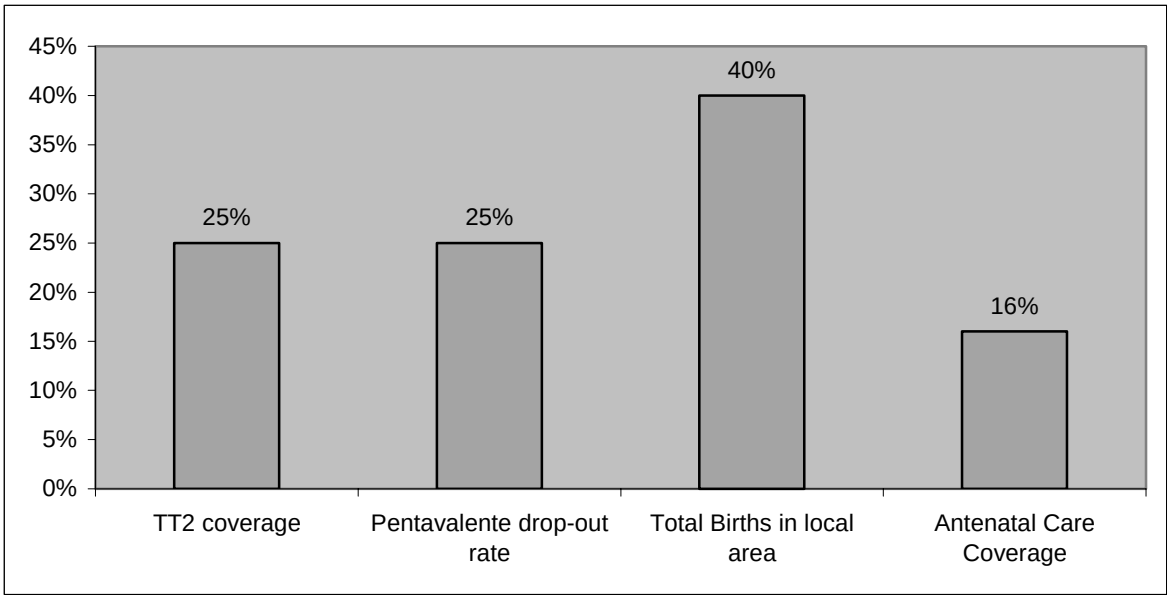
The data collected for the HIS is not currently utilized to its full potential. The survey asked health center staff to report the number of outpatient visits, family planning visits, antenatal visits, deliveries, and pentavalente applications. As Figure 17 indicates, 25 percent of the health centers interviewed were unable to report the number of outpatient visits for any period in the previous six months. For antenatal care visits, only 14 percent of health centers were unable to provide a service provision statistic, but the percentage increased to 34 percent when they were asked for the number of deliveries conducted by the facility and its associated midwives. Data on family planning visits and pentavalente applications fell between these two extremes, with 19 percent and 26 percent of facilities unable to calculate visits, respectively.

Figure 17: Percent of Health Centers Unable to Report Utilization Statistics



The directors' ability to interpret and understand their utilization data is another challenge to data use. Figure 18 indicates that one facility in four could not estimate from their registers, reports, or charts their tetanus toxoid coverage among pregnant women, and another 16 percent could not estimate their antenatal care coverage. When asked how many children receive their first but not their third pentavalente vaccination, 25 percent of facility directors could not estimate the pentavalente drop-out rate for their population. Furthermore, 40 percent of the staff interviewed could not estimate the number of children born each year in their service area. This lack of data on births is of particular concern because it indicates that directors may lack the ability to assess the validity of their immunization coverage rates and ascertain if all children have indeed received the necessary vaccinations.

Figure 18: Health Centers' Data Utilization Problems



There are several explanations why staff did not know the service statistics at their health center or could not process and/or analyze the data collected:

1. The most common explanation was that the facilities had not processed their registers into a usable format for analysis. In all cases, the health centers had their daily service provision registers completed, but many did not have them compiled into a useful format. Many health center staff manually calculated the service provision statistics from the registers during the interviews. Although they collect the data on a daily basis, many health centers are processing their data only for their quarterly evaluation reports.

2. Staff do not perceive collecting data and using it for planning and management as a priority. The supervisory visits reinforced this fact. Of the 86 percent of facilities that received oversight visits in the last six months, fewer than half of their supervisors checked the facility's statistics or daily registers.

3. Staff may not have the time to analyze the data and may not have the skills to interpret and/or apply the data in decision making.

4.7 Human Resources

4.7.1 Overview of Human Resources

Full control over human resources has yet to be devolved to the SIBASI, but staffing will present challenges to all SIBASIs. Key findings about human resources are as follows:

- All health centers can count on at least one staff member from each cadre of health professional at the delivery site.
- Only half of the medical staff are fully paid by MSPAS.
- Key personnel spend approximately one-third to one-half of their time in nonclinical activities.

4.7.2 SIBASI Administrative Manual's Description of Human Resources

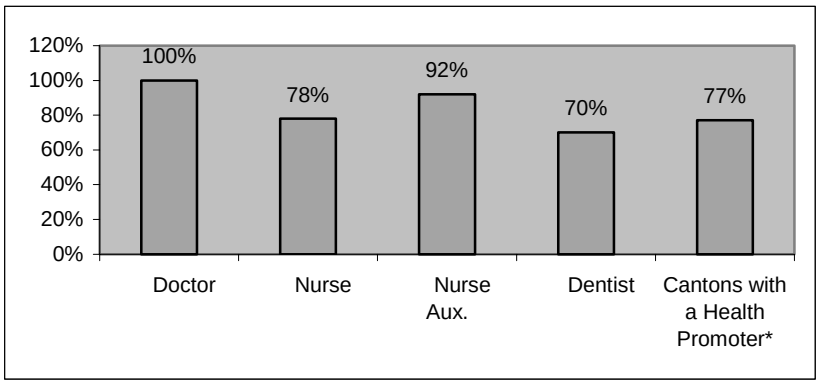
The SIBASI human resources system is for all administrative issues relating to SIBASI staff. These responsibilities include the development of a human resources strategic plan, the recruiting and assigning of staff, professional development, and labor relations. When the baseline and best practices assessment began, several SIBASIs had no formal administrative team and the central Ministry retained many responsibilities related to the human resources system. Although some SIBASIs did inherit administrative staff from the previous departments, multiple human resources duties remained at the central level Ministry. These included the writing and changing of job descriptions, the authorizing of new staff positions, and the setting of salaries.

4.7.3 Key Findings on Human Resources

Finding #1: All health centers can count on at least one staff member from each cadre of health professionals at the delivery site.

All health centers are well staffed with a representation of all categories of staff. As observed in Figure 19, all health centers have at least one doctor, and 92 percent have a nurse auxiliary. Nurses and dentists are less common, with only 78 percent and 70 percent, respectively, of facilities having them on staff. Moreover, all health centers have sufficient health promoters to cover three out of every four cantons.

Figure 19: Availability of Each Staff Category



*Estimate based on a facility's number of promoters/number of cantons

The average staff pattern per health facility masks large differences in the number of staff at smaller health centers. When the large health centers located in urban areas are pooled with the rural facilities, the average health center has 2.6 doctors, 1.0 nurse, 1.9 nurse auxiliaries, 0.9 dentist, and 4.2 health promoters.

Figure 20 lists the average number of clinical staff by category per 10,000 inhabitants in each health center's catchment area (number of doctors divided by the official population assigned to the facility). The seven SIBASIs in this baseline and best practices assessment average 3.6 doctors per 10,000 inhabitants. The second largest category consists of nurse auxiliaries at 2.9 per 10,000, followed by 1.3 nurses and 0.9 dentists.

Figure 20: Average Clinical Staff per 10,000 Inhabitants Assigned to Health Centers

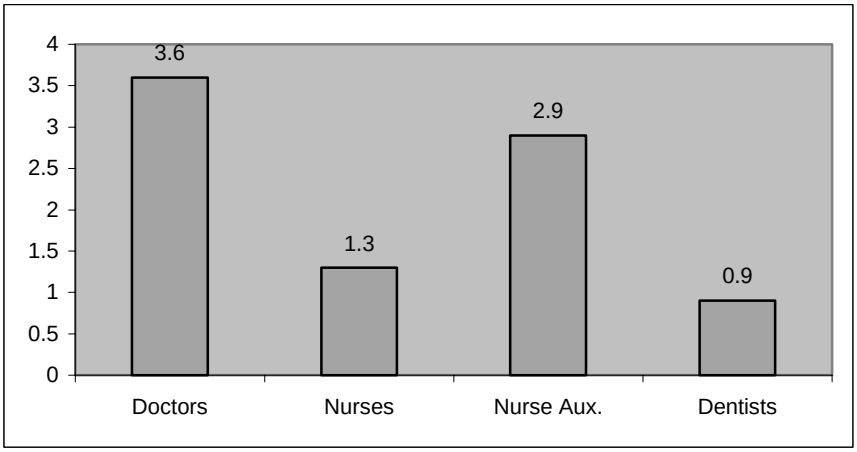


Figure 20 masks substantial variation in clinical resource availability across SIBASIs. For all staff categories except dentists, better staffed SIBASIs have three times as many doctors, nurses, or nurse auxiliaries per 10,000 population than the SIBASIs with the least staff. For doctors, the best staffed SIBASI has 4.6 health center physicians per 10,000 inhabitants compared with 2.1 physicians for the SIBASI with the lowest number of doctors available. The largest differences are for nurses and nurse auxiliaries with differences of 2.6 vs. 0.6 for nurses and 5.6 vs. 1.4 for nurse auxiliaries per 10,000 inhabitants.

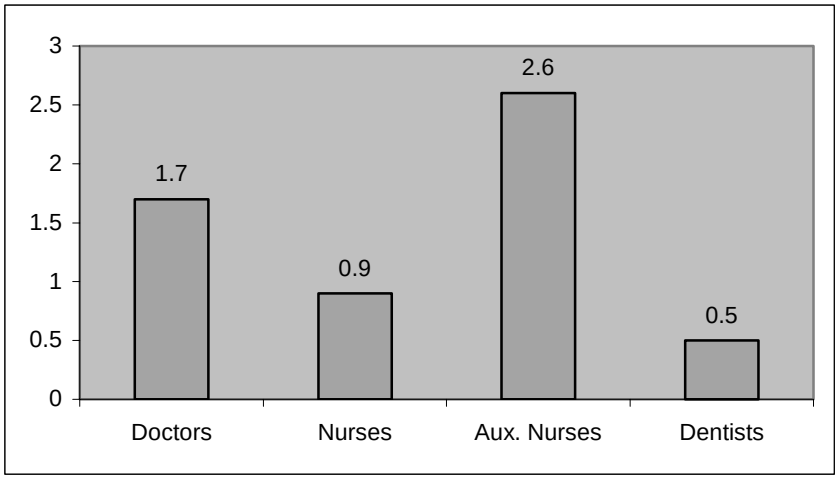
A particular concern evident from Figure 20 is the very low number of nurses available in the study SIBASIs. On average, these SIBASIs have 0.36 doctors per 1,000 citizens, and only 0.13 nurses and 0.29 nurse auxiliaries. If all nursing staff are combined, these facilities can count on only one nurse (either licensed or auxiliary) per doctor. Since physicians' time is consumed by administrative duties and curative consultations, nurses perform most preventive care and conduct all education programs in the community (excluding education conducted by the health promoters). Since most doctors commute from San Salvador, San Miguel, or Zacatecaluca, nurses residing locally are the only clinical resource available to the local population after facilities close for the evening.

Finding #2: Only half of the medical staff are fully paid by MSPAS.

Figures 20 and 21 offer an interesting comparison. By comparing total staff to the number of staff salaries paid by the Ministry, it is clear that the Ministry does not pay the majority of doctors and nurses, but rather they either are contracted locally through cost recovery mechanisms or are partial appointments. The average health center in these SIBASIs receives salaries from the Ministry for 1.7

physicians per 10,000 inhabitants. In addition, the Ministry pays the salaries for an average of 0.9 nurses, 2.6 nurse auxiliaries, and 0.5 dentists per 10,000 inhabitants. In fact, one SIBASI with a high number of doctors per population served has only one in four doctors funded by the Ministry.

Figure 21: Health Center Clinical Staff Paid by Ministry Funds, per 10,000 Inhabitants

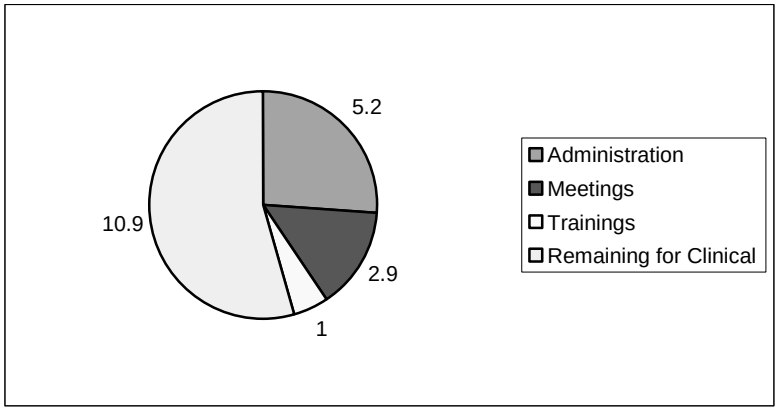


Finding #3: Key personnel spend approximately one-third to one-half of their time in non-clinical activities.

A key challenge for SIBASI management will be freeing sufficient staff time at the facility level to implement the new SIBASI model of integrated care. Many clinical staff such as doctors and nurses spend large percentages of their time in conducting ongoing training activities, performing administrative duties, and fulfilling the tasks required to support the SIBASI (managerial committee, social consultation, collaboration with local leaders, and other duties). This assessment estimates how many days per month doctors and nurses spend in meetings, in training sessions, and on administrative duties. Staff interviewed were asked to estimate the number of days per month they spend away from the facility for training sessions and meetings. They were also asked how many hours per day they spend on administrative duties. Figures 22 and 23 convert all responses to days per month and estimate the number of days spent on nonclinical duties.

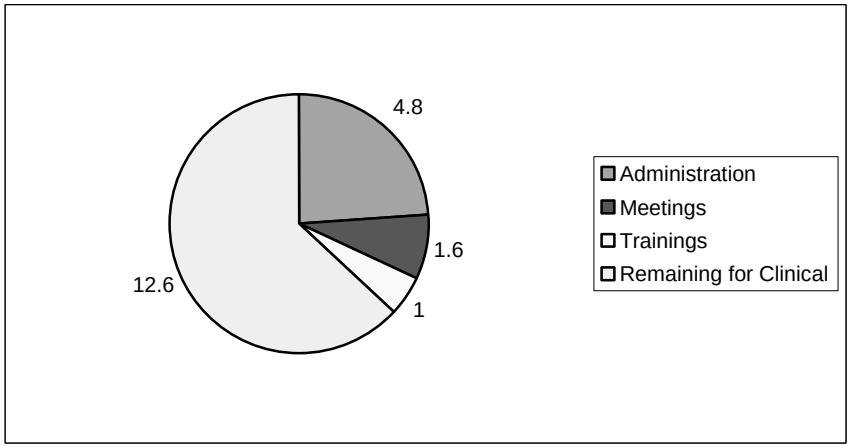
Figure 22 indicates that doctors spend approximately 46 percent of their time on nonclinical duties. Doctors average 2.9 days of their 20 workdays each month in meetings related to the SIBASI, with local government, or in other meetings outside of the facility. Doctors also average 26 percent (or 5.2 days) of their time on administrative duties in the facility. Although all training sessions had been cancelled in the previous three months due to the national dengue emergency, doctors estimated they spent one day a month in training sessions. With some training sessions likely forgotten over the intervening months, this estimate could be considered low.

Figure 22: Days per Month Physicians Spent on Nonclinical Activities



Nurses spend less but still substantial amounts of time on nonclinical activities; approximately 37 percent of their time is spent on nonclinical activities. As Figure 23 illustrates, nurses spend 4.8 days in administration, 1.6 days in meetings, and another 1.0 day in training sessions each month. Based on these totals, doctors and nurses spend roughly 9.1 and 7.4 days, respectively, out of 20 work days per month on nonclinical duties.

Figure 23: Days per Month Nurses Spent on Nonclinical Activities



4.8 Supervision and Oversight

4.8.1 Overview of Supervision and Oversight

SIBASI administrators actively monitor health centers through direct visits and statistical oversight, but the current system lacks a clear focus. The following key findings on supervision and oversight were observed during the assessment:

- The HIS provides an active and functioning system to monitor SIBASI activities.
- A majority of health centers receives supervisory visits on a regular basis.
- There are no clear standards and expectations for what supervisors should do when visiting a facility.

4.8.2 Description from SIBASI Administrative Manual on Supervision and Oversight

The baseline and best practices assessment focused on identifying the oversight system inherited from the departments that will serve as the foundation for the SIBASI oversight system. The responsibilities planned for the oversight system (*Sistema de Control*) in the SIBASI reforms can best be characterized as general administrative oversight. This system is responsible for epidemiological monitoring, client satisfaction, quality control, inventory control, financial oversight, and personnel oversight.

The SIBASI inherited a very extensive, but disjointed and burdensome oversight infrastructure. The challenge facing the SIBASI is to take the existing system and convert it into a low-cost monitoring system that collects sufficient information to guarantee quality and efficiency but that does not create a burden that offsets the gains from decentralization. The current system is best described from the facility perspective and consists of the SIBASI and Ministry monitoring data collected at the facility and direct supervision through site visits.

4.8.3 Findings on Supervision and Oversight

Finding #1: The HIS provides an active and functioning system to monitor SIBASI activities.

The SIBASIs have inherited a very active monitoring system, with facility monitoring based on the annual operating plans (described in Section 4.2). Every three months, facilities prepare for quarterly evaluations conducted by the SIBASIs. In these evaluations, facility performance is based upon the facility's "coverage" of the planned visits and targets listed in the facility's annual operating plan.

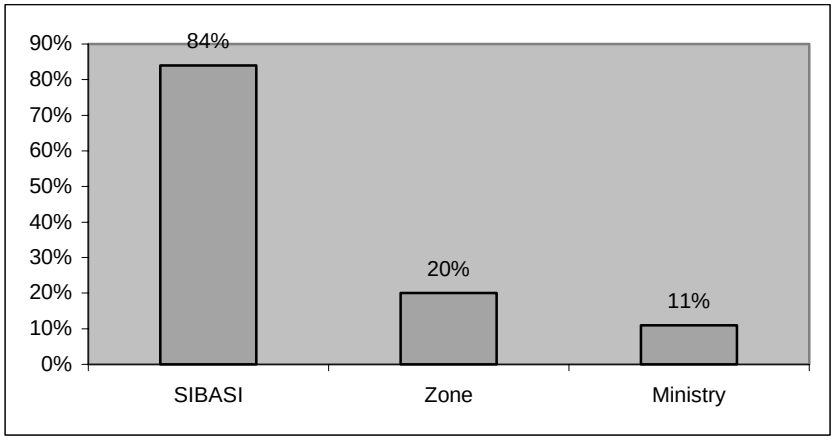
The SIBASI directors believe, however, that the monitoring system lacks a clear focus. The health center directors actively monitor their own performance regarding coverage of their targets in anticipation of their quarterly evaluation. For example, one health center director explained that if he is lagging in his goal for pentavalente applications, he sends a nurse into the community to identify and vaccinate a needy child so that the facility can meet its goal. Facility directors' responsiveness to their targets in the AOP is a true strength of the current system, but this benefit is diluted because the SIBASIs attach targets to all utilization statistics. The overwhelming number of targets fails to communicate clear priorities to the facility directors. Rather than prioritizing which targets are of foremost importance, all are treated equally in the AOP. Experienced directors develop a clear sense of what the SIBASI management rewards and set their priorities accordingly. New directors, however, can be easily overwhelmed by the unmanageable list of targets and, therefore, retreat to providing curative patient visits.

A second problem with the monitoring system is its myopic focus on "coverages." Since facility directors are evaluated on coverage of their targets, they attach primary importance to the numeric goal and not its implications for the population. A coverage rate of more than 100 percent generates pride rather than questions. If they are close to 100 percent of their goal, facility directors relax their efforts since they believe they have met their quarterly obligations. The strong emphasis on achieving coverage rates stems directly from the success of the current monitoring/HIS system.

Finding #2: A majority of health centers receives supervisory visits on a regular basis.

Direct supervisory visits compose the second component of the current oversight system. In the six months preceding the facility interviews, 86 percent of health centers received an outside supervisory visit from SIBASI headquarter staff. Figure 24 demonstrates that the SIBASIs have successfully assumed their role of supervision and oversight while other actors are playing a supporting role. Supervisors from the ETZs visited 20 percent of the facilities, and MSPAS headquarter staff visited 11 percent of the health centers.

Figure 24: Facilities Receiving Supervisory Visits



Challenges remain for supervisory oversight and visits. Staffing assignments to the ETZ and SIBASI administrative teams are not linked to the number of facilities, and this results in an imbalanced distribution of staff. If a given SIBASI inherited a department office and staff, then that SIBASI has twice as many technical staff available to conduct the supervisory visits as a neighboring SIBASI with the same number of health centers but half the number of technical staff.

Finding #3: There are no clear standards and expectations for what supervisors should do when visiting a facility.

Table 3 describes a range of activities conducted during supervisory visits, including checking statistic books; discussing problems, policy/admin issues, and clinical protocols; holding staff meetings; observing service provision; and providing feedback. The table also illustrates that there is no clear standard for what should be covered during a facility visit. As much as 70 percent of supervisory visits include observation of service provision or discussion of policy/administrative issues, but in only 47 percent of visits did the supervisor check utilization registers. This lesser emphasis on supervision of data collection may reinforce facility directors' low utilization of data as well as the data quality issues discussed in Section 4.6.

Table 3: Facilities Receiving Supervisory Visits and Activities Conducted During Visit

Activity during last visit included:	All health centers
Checked statistics or books	47%
Discussed problems	96%
Discussed policy/admin issues	70%
Discussed clinical protocols	67%
Held staff meeting	65%
Observed service provision	72%
Provided feedback	76%

Given the oversubscription of facility directors' time and the heavy reliance on temporary directors in some SIBASIs, supervisory visits need to send clear signals indicating the priorities of MSPAS leadership for improving all facilities. Priorities must be set to guide facility directors in the use of their limited time. Supervisory visits must focus on and reinforce MSPAS priorities. As facilities improve, additional components can be addressed while maintaining status checks to ensure that components addressed earlier continue to function effectively. Current supervisory visits emphasize different SIBASI components from visit to visit, leaving facility directors without clear guidance. This lack of direction can result in diluting the efforts of facility directors and prevent consistent improvement.

Finally, the ETZs are a valuable but underutilized resource. MSPAS envisioned the ETZs as the interface between the central level Ministry and the SIBASI while providing technical support for the implementation of the SIBASI model. Despite this vision, the roles and responsibilities of the ETZ remain unclear. In the absence of clarification on its roles and responsibilities, the scope and content of visits by ETZ have not changed. Facility directors state that ETZ supervisory visits remain similar to those conducted under the department's technical teams and now the SIBASI teams.

4.9 Supplies and Logistics

4.9.1 Overview of Supplies and Logistics

Although health centers have experience managing their own inventory, the actual distribution of pharmaceuticals remains a department and regional activity. The following observations were made regarding the SIBASI supply and logistics system:

- Supply and logistics management has not decentralized to the SIBASI level.
- Storage conditions for commodities at the facility level are good.
- Health facilities experience frequent stock-outs on critical commodities.
- Facilities often do not receive all the supplies and commodities requested.

4.9.2 Description from SIBASI Administrative Manual on Supplies and Logistics

The SIBASI supply and logistics system is responsible for providing all goods required by SIBASI clinics. This responsibility includes planning for facility needs, purchasing, receiving, warehousing, distributing, and providing final oversight of consumable goods.

4.9.3 Findings on Supplies and Logistics

Finding #1: Supply and logistics management has not decentralized to the SIBASI level.

As with all administrative functions, supply and logistics management remains a department level system and has not devolved to the SIBASI level. SIBASIs based in the old department offices handle logistics for all other SIBASIs located in the same department. The departments use a standardized system for purchasing and distributing pharmaceuticals, but some variations exist at the facility level.

In the current system, each facility is responsible for determining its own pharmaceutical needs. Based upon current supplies and historical consumption, each establishment makes its requests to the department administration at fixed intervals. These intervals vary by the type of pharmaceutical, with vaccines requested once per month and all other medication and contraceptives requested every three months. The department administration reviews the request before deciding if the entire order will be sent from the regional warehouse. As supplies are distributed from the regional warehouse, the value of the medication is deducted from the department's account at the Ministry. With their autonomous budgets, hospitals maintain a separate logistics system.

Finding #2: Storage conditions for commodities at the facility level are good.

This assessment focused on the ability of the logistics and supply system to provide, maintain, and store medications at the point of service. Interviewers determined if specific medications had stocked out at any time in the previous six months and examined the inventory control system and the storage area for medication and vaccines. In addition, facility directors were asked to explain the requisition process their facility used and to indicate how often they received all the supplies and commodities requested.

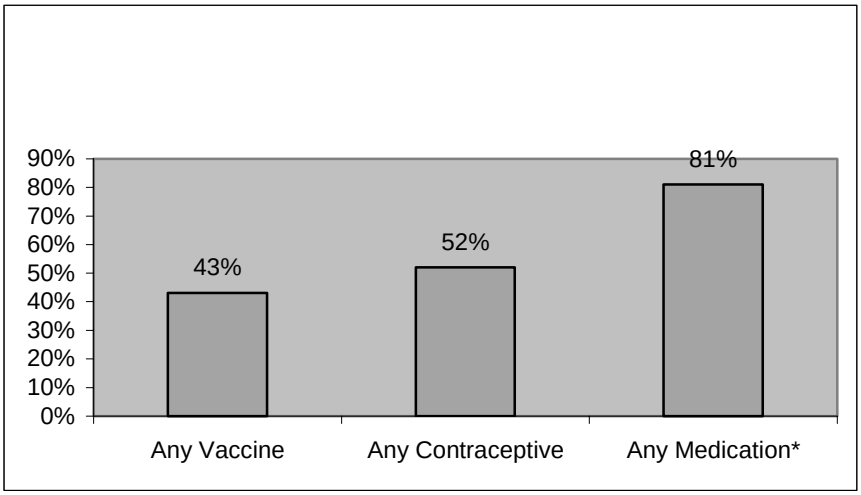
Findings from interview observations as well as staff responses to survey questions indicated that storage conditions for medications were generally good, with all facilities storing their drugs off the floor, protected from moisture and direct sunlight, and free from any evidence of pests.

Finding #3: Health facilities experience frequent stock-outs on critical commodities.

General: As Figure 25 demonstrates, health facilities experience frequent stock-outs on vaccines, contraceptives, and basic medications. The facility interviews collected data on stock-outs in the last six months for five vaccines, four contraceptive methods, and nine basic medications.

Health centers were less likely to stock out of vaccines than other pharmaceutical supplies, as shown in Figure 25. For the five vaccines considered, 43 percent of health centers did not have one of these vaccines on hand at some period in the previous six months. Similarly, 52 percent of facilities stocked out of one of the four contraceptive methods and 81 percent stocked out of at least one of the basic medications.

Figure 25: Stock-outs of Pharmaceuticals in the Last Six Months



*Stock-outs of any of the nine medications considered

Vaccine stock-outs: Despite some difficulties, all the basic building blocks for a vaccine logistics system are in place and functioning. All facilities store their vaccines in an area protected from direct sunlight, and 93 percent of health centers had a completed, up-to-date cold chain monitoring chart for the refrigerator used to store vaccines.

Table 4 describes the percentage of facilities that experienced a stock-out by type of vaccines. As the table illustrates, more than 40 percent of all facilities interviewed experienced a stock-out in one of the vaccines during the last six months. For individual vaccines, stock-outs ranged from 7 percent for BCG to 21 percent for pentavalente.

Table 4: Stock-outs of Vaccines in the Last Six Months

Vaccine	Percent of Facilities with Stock-out (All SIBASIs)
BCG	7%
Oral Polio	10%
MMR	13%
Tetanus Toxoid	18%
Pentavalente	21%
Any vaccine	*43%*

Contraceptive stock-outs: Table 5 indicates that stock-outs of contraceptives were more problematic than vaccines. In the previous six months, more than half (52 percent) of facilities stocked out of pills, IUDs, injectables, or condoms. Maintaining the most popular method in stock was most problematic, with 31 percent of facilities not having injectables available at least once in the last six months. Condoms proved the least problematic, although 20 percent of facilities still did not have them available at least once in the last six months.

Table 5: Stock-outs of Contraceptives in the Last Six Months

Contraceptive	Percent of Facilities with Stock-out (All SIBASIs)
Condoms	20%
IUDs	24%
Pills	27%
Injectables	31%
Any contraceptive method	*52%*

General medications stock-outs: Table 6 indicates that facilities had even greater difficulties in maintaining sufficient stocks of general medications. For the nine medications considered, 81 percent of facilities experienced a stock-out of at least one in the previous six-month period. Facilities achieved most success with maintaining penicillin in stock; only 12 percent experienced stock-outs of this medication. Two medications proved especially problematic: Metronidazol and expectorant. For Metronidazol, 38 percent of facilities stocked out and a full half of establishments experienced a stock-out of expectorant in the previous six months.

Table 6: Stock-outs of General Medication Logistics in the Last Six Months

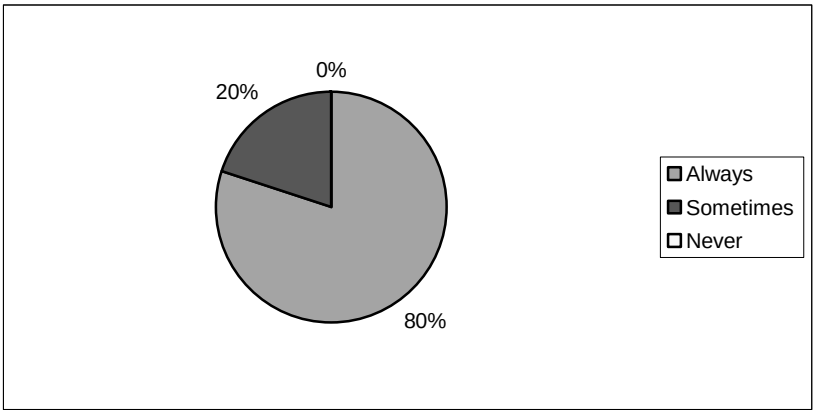
General Medication	Percent of Facilities with Stock-out (All SIBASIs)
Penicillin	12%
Trimetroprin Sulfa	13%
Amoxicillin	15%
Folic Acid	15%
Acetaminophen	21%
Mebendazol	22%
Vitamin A Capsules	31%
Metronidazol	38%
Expectorant	50%
Any medication	*81%*

Finding #4: Facilities often do not receive all the supplies and commodities requested.

There was considerable variation in the timing and frequency with which facilities ordered contraceptives and medications. For example, some facilities ordered vaccines and contraceptives at the same time while others ordered them on different schedules. Up to 33 percent of facilities ordered contraceptives with the same frequency as vaccines (every four weeks) while the other 66 percent ordered contraceptives supplies on a schedule of every 12 weeks. Such variation in the schedules for ordering contraceptives was even seen among facilities within the same SIBASI. Facilities also varied in the frequency with which they ordered medications. As much as 82 percent ordered medications every 12 weeks while 11 percent ordered medications every 24 weeks.

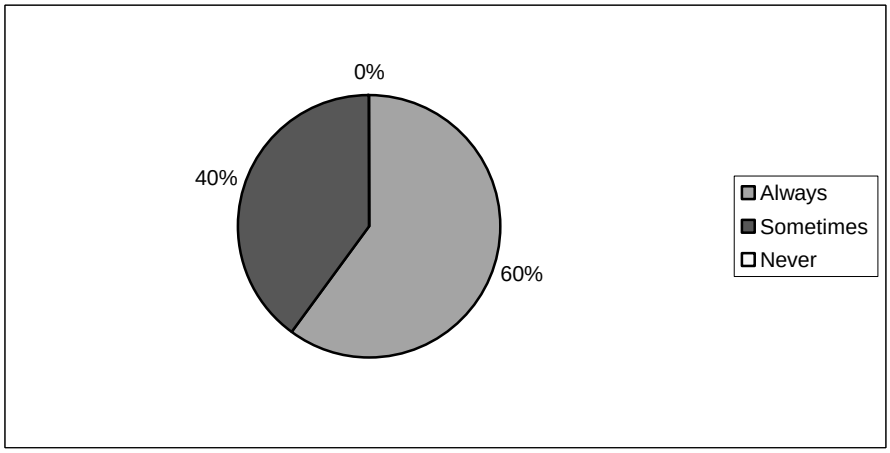
Figure 26 illustrates the percentage of facilities receiving all vaccines requested. Clearly department administrators are responding to facilities' requests for supplies of vaccines. When asked how often they receive their entire requested shipment of vaccines, as much as 80 percent of health centers answered "always" and only 20 percent answered "sometimes."

Figure 26: Percent of Facilities Receiving Entire Vaccine Request



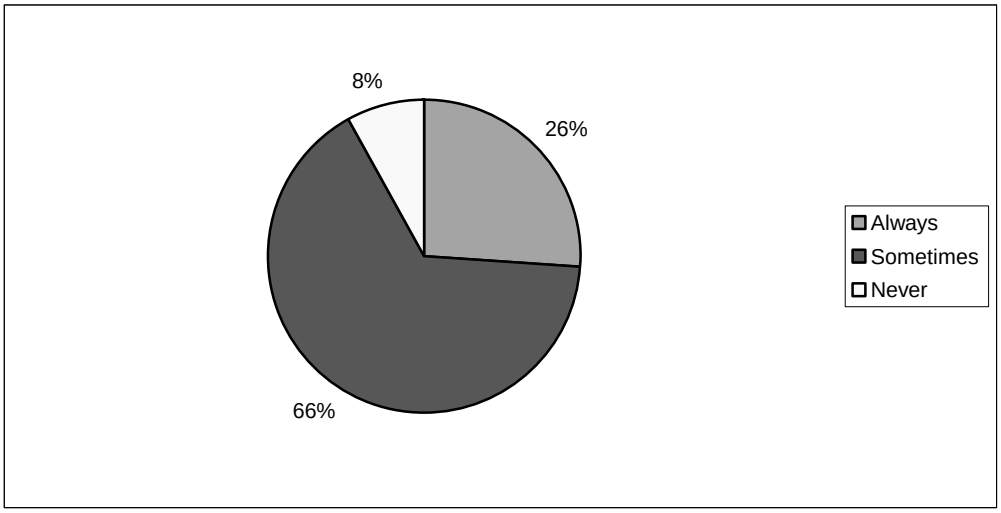
In contrast to vaccine requests, Figure 27 indicates that only 60 percent of health centers always received the entire shipment of contraceptives requested; 40 percent received it "sometimes."

Figure 27: Percent of Facilities Receiving Entire Contraceptive Request



As Figure 28 indicates, only 26 percent of the facilities interviewed responded that they always received their entire order for basic medications. In contrast, 66 percent reported that they sometimes received their entire request and another 8 percent responded that they never received the full order.

Figure 28: Percent of Facilities Receiving Entire Request for General Medications



4.10 Social Participation

4.10.1 Overview of Social Participation

Systematic social participation is a fundamental difference between the SIBASI model and the previous department model, and the SIBASIs have made strong efforts to develop this new component. The following key findings regarding social participation were made during the assessment:

- SIBASI administrators are reaching out to community leaders.
- The majority of facilities hold meetings with the community.
- A majority of facilities make changes in response to community input.
- SIBASIs frequently requested direction and assistance in how to implement the social participation component.

4.10.2 Description from SIBASI Administrative Manual on Social Participation

In accordance with its mission, the SIBASI management structure formally incorporates the community through a social consultation committee (*Instancia de Consulta Social*). Through this committee, the community is encouraged to do the following:

1. Participate in the creation of the SIBASI's annual plans to address the community's health needs
2. Participate in the implementation of the annual plans
3. Conduct social oversight of SIBASI actions and services

4.10.3 Findings on Social Participation

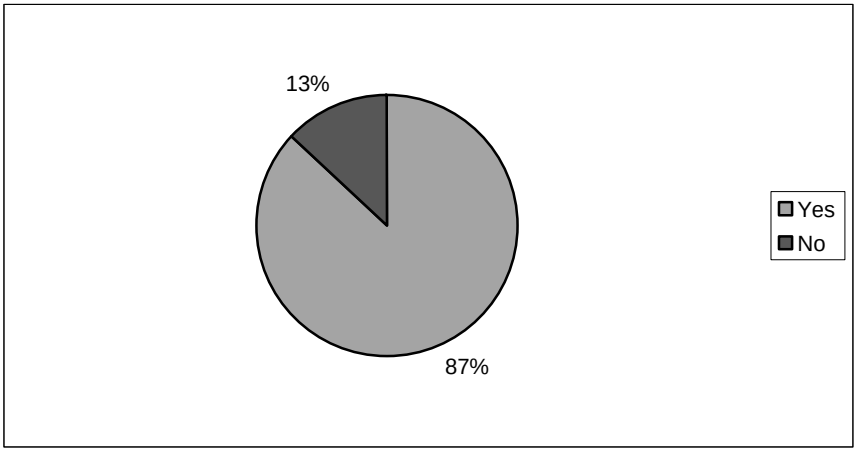
Finding #1: SIBASI administrators are reaching out to community leaders.

Most SIBASI directors have focused their efforts to reach the community on community leaders, on explaining the SIBASI model and what it involves, and on explaining the role of the community in its full implementation. SIBASI directors have also conducted multiple presentations on the formation and implementation of the new SIBASI model. Directors have made efforts to maintain open lines of communication with the community, and, in multiple cases, this new communication is beginning to pay dividends. Local governments have assisted with local funding shortfalls stemming from the elimination of "user fees" at the facility level. In one SIBASI, the community provided funding to purchase computers for 63 percent of the health centers. In the same SIBASI, the director reported success at involving the private sector, with the local banks providing venues for presentations and some assistance with communication materials.

Finding #2: The majority of facilities hold meetings with the community.

Figure 29 indicates that 87 percent of facilities held periodic meetings with some form of community involvement. All of these meetings at the facility level are related to the municipal community health committees. It should be noted that these are not the social consultation committees described in the SIBASI manual, but are standing local committees predating the SIBASI reforms.

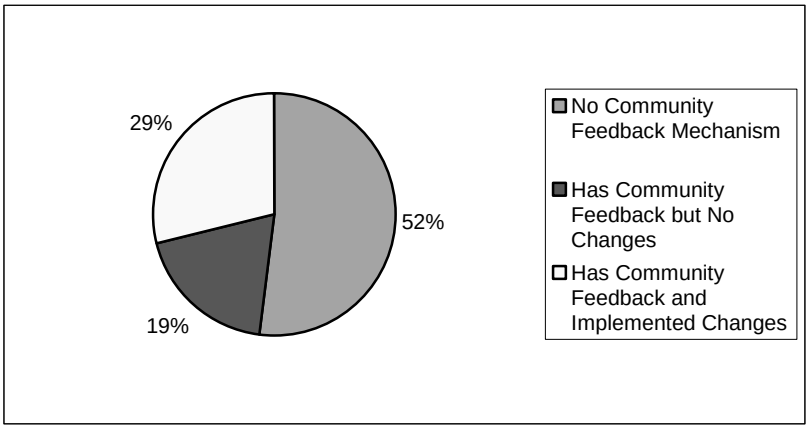
Figure 29: Percent of Facilities Holding Periodic Meetings with Community Involvement



Finding #3: A majority of facilities make changes in response to community input.

In addition to involving the community at health center meetings, primary care facilities accept and respond to client feedback. Figure 30 indicates that 48 percent of health centers utilize at least one form of an organized client feedback system. More importantly, 29 percent of all facilities report making a change based upon client feedback.

Figure 30: Percent of Facilities with an Organized Client Feedback Mechanism



Finding #4: SIBASIs frequently requested direction and assistance on how to implement the social participation component.

The SIBASI administrative manual provides a three-page overview of social participation, but SIBASI directors frequently voiced their concern that the manual does not offer guidelines on how to implement this component. With this limited information, each SIBASI has taken a substantially different approach to social participation, with varying emphasis on four broad dimensions:

- Communicating the SIBASI concept
- Obtaining resources from the community
- Involving the community in decision making
- Involving the community in oversight of providers

SIBASI directors asked MSPAS leadership for more direction and assistance on how to implement social participation. The area of most concern to the SIBASI directors is how to involve the community in decision making and oversight. Many of the directors have ideas and proposals on how to involve the community but are hesitant to proceed. Given the importance of community involvement, the SIBASI directors expect MSPAS will issue new guidelines on social participation. They do not want to start a participatory process with community leaders and be told later by MSPAS to take a different approach. SIBASI directors fear this would result in a considerable loss of credibility. Consequently, most SIBASI directors stated they are proceeding cautiously until they receive further direction from MSPAS.

4.11 Maintenance and Infrastructure

4.11.1 Overview of Maintenance and Infrastructure

As the SIBASIs assume responsibility for facility maintenance, creative approaches will be needed to improve upon the current maintenance performance. The following observations were made regarding maintenance and infrastructure:

- The maintenance system remains at the department level.
- All SIBASI facilities are functioning with basic services.
- The current maintenance system is inadequate to prevent interruptions in basic services.
- SIBASI-wide maintenance systems do not exist.

4.11.2 Description from SIBASI Administrative Manual on Maintenance and Infrastructure

The proposed SIBASI maintenance system is tasked with providing technical support related to the maintenance of SIBASI facilities and with managing the facilities' physical plant and assets.

4.11.3 Findings on Maintenance and Infrastructure

Finding #1: The maintenance system remains at the department level.

As with other administrative functions, the SIBASIs have yet to establish and assume responsibilities for maintenance systems. This function remains a department responsibility.

Before the elimination of user fees (*cuotas voluntarias*) for ambulatory care in June 2002, MSPAS facilities utilized three distinct resources for maintenance and repair needs:

- Department maintenance funds and personnel
- Hospital maintenance funds and personnel
- Local cost recovery funds from user fees

A SIBASI occupying the old department offices could draw upon a limited maintenance fund in the department budget to effect repairs at its facilities. If a SIBASI did not occupy the department offices and have direct access to the maintenance budget, it could petition the SIBASI managing the department resources to assist it with repairing its facilities. If not successful with this first option, the SIBASI might draw upon the maintenance funds and personnel of the local hospital. The hospital option proved practical only if the hospital director doubled as the SIBASI director. SIBASIs lacking access to the department or hospital maintenance resources required their facilities to perform maintenance using local cost recovery resources. Although a facility director could obtain assistance for structural repairs through the SIBASI or department administration, the director had to rely entirely on cost recovery funds for minor structural repairs (e.g., a broken window) or for repairing minor equipment. At the time this baseline and best practices assessment was being conducted, user fees were being eliminated and, therefore, the assessment could not measure the impact of this loss of revenue on the SIBASIs.

Finding #2: All SIBASI facilities are functioning with basic services.

Table 7 indicates the percentage of SIBASI health facilities that are equipped with basic services. All facilities are electrified, and 83 percent have a telephone or shortwave radio to communicate outside the facility. Access to clean water is still a major problem, with only 58 percent of health facilities having potable water. Clients can expect the physical facilities to be acceptable, with 97 percent of facilities rated as clean, 99 percent of facilities having a waiting area shielded from sun and rain, and 96 percent having functioning toilets for clients. Additional attention will be needed for medical waste disposal, however;

only 65 percent of facilities had their medical waste protected in some form (buried, covered, incinerated) at the time of the interview.

Transportation supporting the facilities remains a problem. Fewer than one-third of the facilities had access to an ambulance. Approximately 39 percent had access to a motorcycle and 7 percent had access to other forms of transportation. These averages mask considerable disparities among facilities. In the best equipped SIBASI, 67 percent of its facilities had access to motorcycles while, on average, 39 percent all health facilities across all seven SIBASIs had access.

Very few health facilities had access to computers. Only 17 percent of all facilities had a computer, although in one SIBASI, 63 percent of its facilities had computers. Factors explaining the differences in computer access include differences in allocation of central resources and a local initiative by one SIBASI to mobilize community resources to equip each facility with a computer.

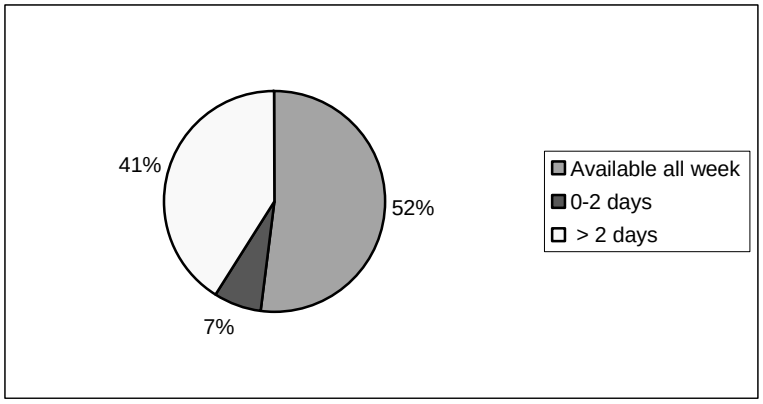
Table 7: Installed Infrastructure at Facilities

Infrastructrure Component	Percent of Facilities with Infrastructure (All SIBASIs)
Electricity (any source)	100%
Potable water	58%
Functioning toilets	96%
Clean facility	97%
Waiting area protected from sun and rain	99%
Medical waste protected	65%
Telephone	78%
Shortwave radio	7%
Telephone or shortwave radio	83%
Computer	17%
Ambulance	28%
Other vehicle	7%
Motorcycle	37%

Finding #3: The current maintenance system is inadequate to prevent interruptions of basic services.

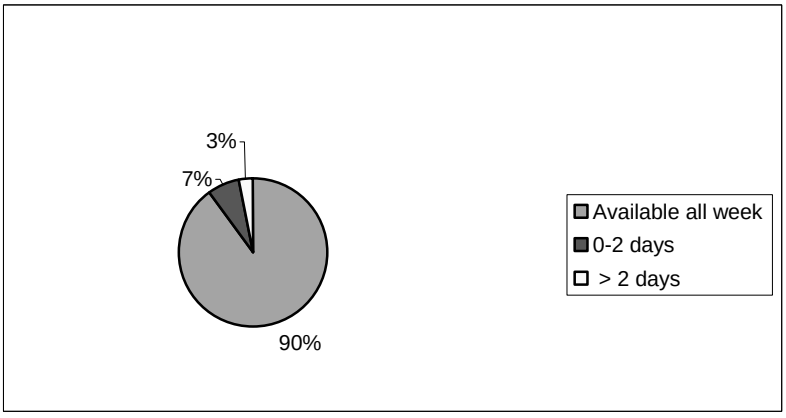
As Figures 31 and 32 indicate, the current maintenance systems are inadequate to prevent interruptions of basic services such as water and electricity. Interruptions in the supply of potable water occur frequently, with 41 percent of facilities experiencing an interruption of at least two hours in the week preceding the assessment interview. Interruptions last a while, with an average break in service lasting 4.2 days. Approximately one-third of all facilities had no potable water for the entire week prior to the interview.

Figure 31: Potable Water Service Interruptions at Health Centers



Electricity supplies are much more consistent, with only 10 percent of facilities experiencing an interruption. The breaks in electricity services averaged 1.6 days.

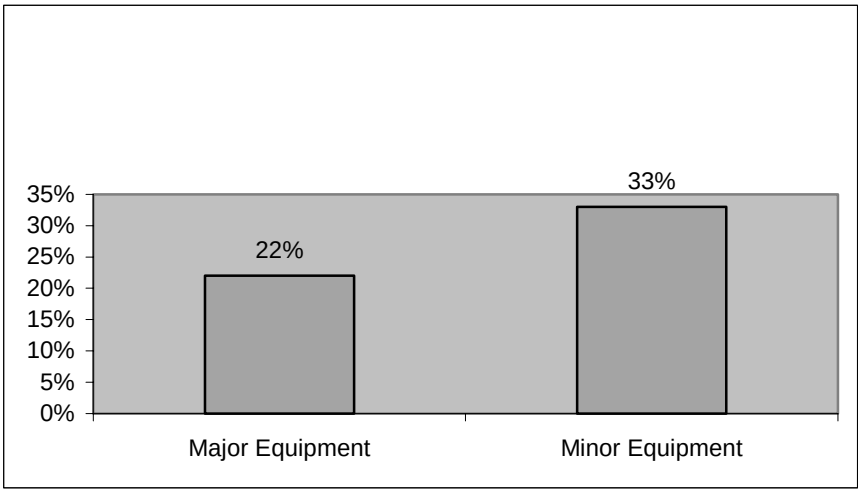
Figure 32: Electricity Interruptions at Health Centers



Finding #4: SIBASI-wide maintenance systems do not exist.

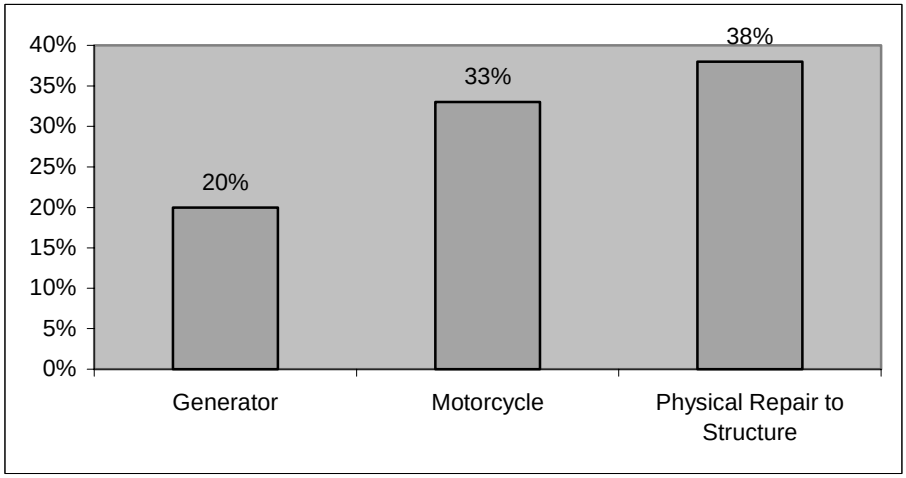
Figure 33 indicates that only 22 percent of facilities could identify an internal or external source for systematic preventive maintenance for their major equipment (e.g., vehicles, refrigerators) and only 33 percent of facility directors could identify any process, including the SIBASI, for repairing damaged minor equipment. Some facilities (15 percent) reported being able to repair their own equipment such as blood pressure cuffs, stethoscopes, and other minor equipment. Problems with equipment maintenance may be further exacerbated with the elimination of "user fees" at the facility level. Previously, facility directors could use these funds to make minor repairs as needed. Currently they have neither funds nor systems to make repairs and many elect to use their own personal medical equipment due to the poor condition of facility equipment such as stethoscopes.

Figure 33: Maintenance and Repair Systems



The current maintenance and repair systems are inadequate to maintain the existing structures and equipment the health centers possess. As indicated in Figure 34, in facilities equipped with a generator, 20 percent are inoperable or lack fuel. In addition, 33 percent of all motorcycles are inoperable, and 38 percent of facilities are in need of some physical repair to the structure (broken windows, damaged walls).

Figure 34: Damaged and Inoperable Infrastructure



4.12 Service Provision of Basic Health Services

4.12.1 Overview of Service Provision of Basic Health Services

SIBASI health facilities provide a broad range of basic health services, but the new SIBASI model will require additional development of outreach services. The following observations were made regarding the provision of basic health services:

- Most facilities offer extended hours of services.
- Each facility offers a broad range of primary care services.
- Temporary family planning contraceptive methods are available.
- SIBASI facilities have strong community-based children's health services.
- SIBASIs offer limited primary health care services in other settings.

4.12.2 Description from SIBASI Administrative Manual on Provision of Basic Services

The SIBASI reforms outline a service provision system organized around integrated care for all age groups in multiple environments (the family, community, school, work place, and the health care facility). The baseline and best practices assessment identified the services currently being offered and where these services are being offered.

The SIBASIs inherited a very extensive, facility-oriented model of care from the departments. Of the five health care environments outlined by the SIBASI model, facility-based care received the most emphasis and resources under the departments. The seven SIBASIs in this assessment average one health center for every 10,000 inhabitants. As a result, basic services are fairly accessible through these facilities.

4.12.3 Findings on Service Provision

Finding #1: Most facilities offer extended hours of services.

Facilities schedule services so they are accessible, given clients' schedules, with some health center services offering expanded hours and/or services seven days a week. A full 98 percent of these facilities are open a minimum of seven hours per day, from 8:00 a.m. until 3:00 p.m., five days per week. Many facilities have increased hours of operations, with 90 percent of facilities open until 4:00 p.m., and 14 percent remaining open all seven days per week. After the facilities have closed for the evening, service availability becomes substantially more limited, with only 33 percent of facilities having a staff member officially on call when the facility is closed. The facilities' hours of service are shown in Table 8.

Table 8: Average Hours of Operation for Health Centers

Hours of Operation	% of Facilities
Open five days per week	98%
Open seven days per week	14%
Open by 8:00 a.m.	100%
Closing at 3:00 p.m. or later	100%
Closing at 4:00 p.m. or later	90%
Staff officially on call when facility is closed	33%

Finding #2: Each facility offers a broad range of primary care services.

As Table 9 indicates, each facility offers a very broad, and consistent package of primary care services. Every facility offers family planning, sick child consultation, growth monitoring, oral rehydration therapy, and prenatal care five days per week. Vaccination services face only slight scheduling limitations with routine vaccinations available all week at 98 percent of facilities and BCG availability at 91 percent of facilities.

Table 9: Health Centers Offering Services Five Days per Week

Services	% of Facilities
Family planning	100%
Sick child consultation	100%
Growth monitoring	100%
Routine vaccination	98%
BCG vaccination	91%
Oral rehydration therapy	100%
Respiraratory infection consultation	100%
Prenatal care	100%
Tetanus toxioid for pregnant women	100%

Finding #3: Temporary family planning contraceptive methods are available.

Clients can obtain most temporary contraceptive methods during the five-day workweek, as shown in Table 10. Pills, injectables, and condoms are distributed every workday at 99 percent of the health centers. Natural family planning counseling is also available in 91 percent of facilities at least five days per week. IUDs are less available than the other temporary contraceptive methods, with approximately 56 percent of the facilities offering IUDs during the week.

Table 10: Contraceptive Method Availability at Health Centers

Family Planning Methods	% of Facilities
Pills	100%
IUD	56%
Injectables	99%
Condoms	99%
Natural family planning counseling	91%

Finding #4: SIBASI facilities have strong community-based children's health services.

Table 11 identifies children's health services offered by health promoters. The first column details the type of services offered, the second column indicates the percentage of facilities offering the service five days per week, and the third column presents the average number of days the particular services is offered each month.

Table 11: Profile and Schedule of Community-Based Services Offered by the SIBASI

Services Offered in the Community	% Facilities Offering Five Days per Week in Community	Avg. # Days per Month Offered in Community
Oral rehydration therapy	93%	19.0
Sick child consultation	68%	14.9
Growth monitoring	72%	15.2
Routine vaccination	49%	11.7
BCG vaccination	12%	3.2
Respiratory infection treatment	74%	15.3

The most widely offered service by community workers is oral rehydration therapy (ORT), with 93 percent of facilities' health promoters offering ORT five days per week (or 19 of the 20 workdays in a month). As much as 68 percent of health promoters offer sick child consultation and 72 percent provide growth monitoring. Vaccinations are substantially less available through community-based care, with only 49 percent of facilities offering routine vaccinations through their health promoters and 12 percent offering BCG vaccinations five days per week. For BCG vaccinations, the average facility offers the immunization in the community only 3.2 days per month.

Finding #5: SIBASIs offer limited primary health care services in other settings.

Services offered in other health care settings (family, school, and workplace) were available intermittently and on a program-by-program basis. Most facilities have an active healthy schools program operated by their nursing staff.

5. Next Steps

This SIBASI baseline and best practices assessment will be disseminated to multiple audiences in a variety of events to ensure that all relevant actors have the data and the opportunity to discuss its implications. The first dissemination event was held in September 2002 in San Salvador. The PHR*plus* Project facilitated a series of meetings to present the preliminary findings to MSPAS leadership and to the directors of the seven USAID priority SIBASIs.

MSPAS had programmed other dissemination activities, including the following:

- MSPAS will hold a one-day conference in February 2003 to present the results to a wide audience, including a larger group of MSPAS staff working at headquarters, SIBASI directors and their administrative teams, and other international organizations working to support SIBASIs.
- MSPAS, with the assistance of PHR*plus*, will conduct one-on-one seminars with the directors and administrative teams from each of the seven USAID priority SIBASIs to present and discuss the assessment results for their specific SIBASI and plan for future technical assistance needs.
- PHR*plus* will sponsor and facilitate bimonthly or quarterly meetings of the seven SIBASI directors to exchange ideas and discuss best practices in implementing the SIBASI model. The first meeting will focus on sharing the findings from the baseline analysis and identifying best practices among the seven SIBASIs to address some of the challenges identified by the baseline.
- In collaboration with MSPAS leadership, PHR*plus* will assist in the development of a monitoring and evaluation system for SIBASIs that will
  - track indicators to monitor components of the newly developed management contracts between the central level Ministry and the SIBASIs;
  - track the progress of each SIBASI in developing and implementing the 11 components of the SIBASI model; and
  - track and monitor the provision of USAID priority health services.

Annex A: Interview Guide

Guia de entrevista para ser usado con los Directores del SIBASI

PRIMERA PARTE: TRASFONDO GENERAL

A. Misión

1. ¿En sus propias palabras, cuál es la Misión o propósito de la estrategia SIBASI?

2. ¿En su opinión, se ha entendido la misión del SIBASI?

   - ¿Al nivel SIBASI?
   - ¿A varios niveles como hospitales, centros de salud, puestos de salud?

3. ¿De qué manera tiene influencia o es una guía en su trabajo la misión SIBASI?

B. Proceso de Implementación SIBASI

1. ¿Qué instrucciones o guías ha recibido de sus superiores en cuanto a cómo implementar la estrategia SIBASI?

   - Tratar de obtener sus opiniones sobre las instrucciones: ¿Informativa? ¿De ayuda? ¿Fácil de comprender? ¿Consistente?
   - ¿La información se dio por escrito o en forma verbal?
   - ¿En qué forma fue provista esta información? (formal, informal, en persona, en una capacitación, en una presentación de Powerpoint, por correo)

2. ¿Qué recursos ha recibido de parte de sus superiores como un apoyo a sus esfuerzos de operacionalizar el SIBASI?

   - Tratar de obtener información en cuanto a qué tipo de servicios: (fondos, personal, asistencia técnica, capacitación, herramientas y metodologías)
   - Tratar de obtener información en cuanto a la calidad de estos servicios: ¿Informativos? ¿De ayuda? ¿Fácil de comprender? ¿Consistente?

3. ¿Qué información y/o recursos cree usted que son esenciales para que usted pueda implementar el modelo SIBASI?

4. ¿Cuál es su prioridad inmediata o su próximo paso a seguir dentro del desarrollo de su SIBASI?

5. ¿Cuál es el obstáculo principal que usted ha encontrado en el proceso de operacionalizar?

6. ¿En qué áreas administrativas y de manejo necesita más apoyo?

7. ¿En qué áreas administrativas y de manejo podría usted dar apoyo a otros SIBASIs?

8. ¿En qué forma podría sus superiores ayudar sus esfuerzos de operacionalizar el SIBASI en este momento?

SEGUNDA PARTE: CINCO COMPONENTES

A. Organización y Administración

Organización y Estructura

1. ¿Podría describir usted el modelo SIBASI?

Además de su descripción, tratar de obtener información en cuanto a qué tanto el o ella percibe el modelo y si es percibido correctamente a diferentes niveles.

2. ¿Qué información ha recibido usted en cuanto a una descripción del modelo SIBASI?

- Tratar de obtener su opinión en cuanto a la descripción del modelo: ¿Informativa? ¿De ayuda? ¿Fácil de comprender? ¿Consistente?
- ¿Forma de entrega (por escrito, verbal, presentación en PP)?
- ¿En qué forma dieron entrega de estas instrucciones sus superiores? (¿formalmente, informalmente, en persona, por medio de capacitaciones, seminarios de políticas, por correo?)

3. ¿Está la estructura del SIBASI en pie y funcionando?

Explorar asuntos tales como:

- ¿Existe un diagrama de organización el cual incluya el personal nuevo?
- ¿Existen descripciones de trabajo del personal?
- ¿Existe alguna vacante dentro de las nuevas posiciones de personal?
- ¿Está bien definido el papel y las responsabilidades para estas nuevas posiciones?

Recursos Humanos

1. ¿Quién determina la necesidad de personal?

Explorar los siguientes temas:

- Si esta función no se hace al nivel SIBASI, entonces preguntar quién la hace y cómo? ¿Qué implicaría a usted el asumir esta función al nivel SIBASI?
- ¿Tiene el SIBASI personal capaz y calificado para administrar esta función? ¿Está usted usando las nuevas Normas y Procedimientos descentralizados como guía para los sistemas de recursos humanos y procedimientos?
- ¿Si no están utilizando las Normas detalladas en el manual SIBASI, preguntar qué sistema de recursos humanos están utilizando?

2. ¿Qué responsabilidades tiene usted para contratar, evaluar, disciplinar y despedir personal en su SIBASI?

- Si esta función no se hace al nivel SIBASI, entonces preguntar quién la hace y cómo? ¿Qué implicaría a usted el asumir esta función al nivel SIBASI?

3. ¿Se evalúa el desempeño de trabajo del personal regularmente? ¿Quién lo hace? ¿Con qué frecuencia?

- Si esta función no se hace al nivel SIBASI, entonces preguntar quién la hace y cómo? ¿Qué implicaría a usted el asumir esta función al nivel SIBASI?

4. ¿Cómo se establecen los salarios? ¿Quién los establece?

- Si esta función no se hace al nivel SIBASI, entonces preguntar quién la hace y cómo? ¿Qué implicaría a usted el asumir esta función al nivel SIBASI?

5. ¿Opina usted que los salarios son competitivos? (Podría el personal ganar más haciendo el mismo trabajo bajo diferentes convenios o bajo otros empleadores?

Suministros, Logística y Mantenimiento

1. ¿En qué forma se determinan las necesidades de medicinas, suministros y equipo?

Explorar los siguientes temas:

- ¿Se están tomando las decisiones al nivel SIBASI o aún se están haciendo al nivel central?
- ¿Bajo qué criterios se determinan las necesidades? (Historial, normas del MSPAS, Plan de Salud)

2. ¿En qué forma maneja y planea su equipo técnico los suministros de equipo médico, medicamentos, servicios y materiales dentro de su SIBASI?

Explorar los siguientes temas:

- ¿El sistema en uso ha sido diseñado por su SIBASI o utilizan uno propuesto por el MSPAS, u otros? (GTZ,OMS)
- ¿Tiene el SIBASI personal en el lugar, capacitado y calificado para administrar esta función?
- ¿Si esta función aún esta siendo provista por sus superiores, entonces preguntar qué implicaría a su SIBASI asumir esta responsabilidad?

3. ¿Es su SIBASI el responsable de la distribución de medicinas, suministros y equipo?

Explorar los siguientes temas:

- ¿El sistema en uso ha sido diseñado por su SIBASI o utilizan uno propuesto por el MSPAS, u otros? (GTZ,OMS)
- ¿Tiene el SIBASI personal capacitado y calificado para administrar esta función?
- ¿Si esta función aún esta siendo provista por sus superiores, entonces preguntar qué implicaría a su SIBASI asumir esta responsabilidad?

4. ¿Cómo maneja el SIBASI las reparaciones, mantenimiento y renovaciones?

Explorar los siguientes temas:

- ¿El sistema en uso ha sido diseñado por su SIBASI o utilizan uno propuesto por el MSPAS, u otros?
- ¿Qué recursos utilizan para el pago de estos servicios?
- ¿Si esta función aún esta siendo provista por sus superiores, entonces preguntar qué implicaría a su SIBASI asumir esta responsabilidad?

Sistemas de Información de Salud

1. ¿Quién está incluido en su sistema epidemiológico?

Explorar lo siguiente:

- ¿Solo los hospitales?
- ¿Todos los establecimientos del MSPAS?
- ¿Algún otro establecimiento público o privado que estén contribuyendo?

B. Servicios Integrados

1. ¿En qué forma promueve el modelo SIBASI un planteamiento integrado para la entrega de servicios?

Explorar los siguientes temas:

- ¿Provee el SIBASI el nuevo paquete básico de servicios?
- ¿Qué tan bien comprenden el nuevo modelo los profesionales de la salud? ¿Y en los diferentes niveles?
- ¿Quién determina las prioridades? ¿Son las prioridades de salud identificadas con la ayuda de los miembros de la comunidad?
- ¿Ha sido modificado el paquete básico para reflejar las prioridades de salud en su SIBASI?

2. ¿Tiene el SIBASI un programa de promoción de salud el cual refleja el nuevo paquete básico de servicio y que a su ves promueve la prevención?

Explorar temas como:

- ¿Funcionan actualmente estos sistemas en el SIBASI?
- ¿Tiene el SIBASI personal con estas habilidades y los recursos necesarios?

3. ¿Cómo funciona el sistema de referencia?

4. ¿Cómo monitorea el SIBASI la calidad de servicios provistos en los establecimientos de salud del MSPAS?

Explorar los siguientes temas:

- ¿Funcionan actualmente estos sistemas en el SIBASI?

- ¿Tiene el SIBASI personal con estas habilidades y los recursos necesarios?

C. Provisión de Servicios

1. ¿Existe un nuevo diagrama de organización de sus unidades de salud en conformidad con la estructura SIBASI?

Si ha sido desarrollado, explorar temas como:

- ¿Es operacional?
- ¿Tiene cada quien copia del nuevo diagrama de organización?
- ¿Qué tan bien es comprendido este diagrama entre el personal en todos los niveles?

Si no, ¿Porqué no?

2. ¿Están las unidades de salud dentro de su SIBASI aplicando las nuevas Normas y Procedimientos?

Si tienen las Normas y Procedimientos explorar temas como:

- ¿Son operacionales?
- ¿Tiene cada quien una copia?
- ¿Qué tan bien son comprendidas estas Normas entre el personal en todos los niveles? ¿Es necesaria una capacitación adicional?

Si la respuesta es no, ¿porqué?

3. ¿Qué clase de apoyo proporciona el personal al nivel SIBASI al personal de los establecimientos de salud, por ejemplo en términos de supervisión, educación continua, etc.?

4. ¿Tiene el SIBASI alguna forma de monitoreo en cuanto a responsabilidades de manejo y administrativas en sus establecimientos de salud?

Explorar temas tales como:

- ¿Emplea el SIBASI algún sistema en particular?
- ¿Tiene el SIBASI personal con las habilidades y recursos necesarios?
- ¿Se les da retroalimentación a los establecimientos de salud?

D. Finanzas

1. ¿Quién desarrolla el presupuesto de su SIBASI?

Explorar los siguientes temas:

- ¿Tiene el SIBASI su propia metodología o utiliza una propuesta por el MSPAS, GTZ, OMS para el desarrollo de sus presupuestos?
- ¿Tiene el SIBASI personal capacitado y calificado para llevar a cabo el desarrollo de los presupuestos?

- ¿Si sus superiores aún están desarrollando sus presupuestos por ellos, entonces preguntar qué necesitarían para tomar esta responsabilidad en su SIBASI?

2. ¿Qué influencia tienen ustedes en cuanto al nivel de fondos que se reciben?

3. ¿Existe un proceso actualmente en su SIBASI de transferencia de fondos?

4. ¿Qué autoridad tienen ustedes sobre a su propio presupuesto?

5. ¿Quién maneja los fondos a nivel SIBASI?

Explorar los siguientes temas:

- ¿Tiene el SIBASI un sistema para recibir, administrar y controlar los fondos (SAFI u otra herramienta computarizada para la administración?
- ¿Tiene el SIBASI personal capacitado y calificado en la administración financiera?
- ¿Recibe usted informes financieros y cómo los utiliza?
- ¿Son auditados estos informes por alguien fuera del SIBASI?

E. Participación Social

1. ¿Se han identificado los involucrados y los grupos comunitarios en su SIBASI?

Si no, ¿porqué? (existe resistencia a la idea? ¿Les han provisto sus superiores con guías y recursos adecuados? ¿Tiene el SIBASI personal calificado y capacitado para llevar a cabo esta función?

2. ¿Se ha establecido el Comité de contraloría y Gestión Social?

Si la respuesta es sí, explorar lo siguiente:

- ¿Han identificado criterios mediante los cuales seleccionar los diferentes involucrados para ser miembros del comité?
- ¿Se han definido los roles y responsabilidades de los participantes del comité?
- ¿Se han identificado áreas de colaboración y prioridades de salud para ser enfrentadas por el SIBASI?
- ¿Se ha desarrollado un plan basado en el manual de SIBASI?

Si su respuesta es no, ¿porqué?

- ¿Existe resistencia dentro del equipo SIBASI o dentro de la comunidad acerca de esta idea?
- ¿Se ha recibido guía y recursos adecuados de parte de sus superiores?
- ¿Tiene el SIBASI personal capacitado y calificado para llevar a cabo esta función?

3. ¿Qué clase de actividades y/o estrategias tiene su SIBASI en colaboración con el Comité de Contraloría y Gestión Social?

TERCERA PARTE: COMUNICACIÓN Y EL PROCESO DE LA TOMA DE DECISIONES

A. Comunicación

1. ¿En qué forma les informaron sus superiores sobre la estrategia SIBASI?

2. ¿Participó usted en el diseño de la estrategia SIBASI?

3. ¿Cómo describiría usted la comunicación entre sus superiores y los trabajadores de campo?

Explorar lo siguiente:

- ¿Qué mecanismos utiliza el MSPAS para comunicarse con el personal de campo? (memorando, boletines informativos, correo electrónico)
- ¿Con qué frecuencia se comunican?
- ¿Qué tipo de información proveen sobre la estrategia SIBASI? (informativa, útil, fácil de entender, consistente)

4. ¿Qué recomienda hacer para mejorar el flujo de información entre sus superiores y el SIBASI?

B. Proceso de Toma de Decisiones

1. ¿En qué forma fue usted informado sobre la creación de su SIBASI?

2. ¿Participó usted cuando se tomó la decisión de crear su SIBASI?

Explorar las siguientes áreas:

- ¿Se le consultó al determinar qué partes geográficas serían incluidas en su SIBASI?
- ¿Se le consultó en cuanto a las responsabilidades del personal de sus equipos?
- ¿Se le consultó sobre las prioridades y dirección de su SIBASI?

3. ¿Qué decisiones deberían volverse a tomar o ser transferidas y a qué plazo para ayudarle operacionalizar su SIBASI?

4. ¿Qué recomendaciones puede usted dar para ayudar a sus superiores transferir decisiones tomadas las cuales sean claves para su SIBASI?

Annex B: Facility Questionnaire/SIBASI Director Assessment Survey

Facility Inventory Questionnaire	
FACILITY IDENTIFICATION	
Name of the facility _____ Municipality _____ SIBASI Name _____ Facility Code SIBASI Number (1=Cojutepeque, 2=Suchitoto, 3=La Paz, 4=San Vicente, 5=Jiquilisco, 6=Usulutan, 7=San Miguel) Type of Health Facility: (1 = Hospital; 2 = Health center; 3 = Health post)	Tel: _____ FACILITY CODE: ☐☐☐ SIBASI NUMBER: ☐ FACILITY TYPE: ☐
INTERVIEW INFORMATION	
Date:_____ Name of the Interviewer _____ Interview Start Time: _____	DAY ..... ☐☐ MONTH..... ☐☐ YEAR ..... ☐☐☐☐ INTERVIEWER CODE . ☐☐ HOUR ..... ☐☐ MINUTES..... ☐☐

Section 1. General Information

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
100	FOR OUTPATIENT SERVICES: FIND THE MANAGER OR MOST SENIOR HEALTH WORKER RESPONSIBLE FOR OUTPATIENT SERVICES WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING: Hello. I am representing the PHRplus, a USAID project. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely anonymous and is not identified with any facility name. We are asking for your help to ensure that the information collected is accurate. If there are sections where someone else is the most appropriate person to provide information, we would appreciate your introducing us to that person. You may choose to stop the interview at any time. Do you have any questions for me? Do I have your agreement to participate? _____ INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate) _____ DATE		
100b	May I begin the interview?	YES.....1 NO.....2	➔STOP
100_a	In which year did this facility first open?	Year Opened: ☐☐☐☐ DON'T KNOW.....9999	
100_b	For how many cantons is this facility responsible?	No. Cantons: ☐☐☐☐ DON'T KNOW.....9999	
101	How many days each week is the facility routinely open for outpatient services?	NUMBER OF DAYS ..... ☐ DON'T KNOW.....8	
101_a	At what time does this facility usually open to attend patients?	TIME OPENS: ☐☐ : ☐☐ NO SABE.....9999	
101_b	At what time does this facility usually stop attending patients?	TIME CLOSES: ☐☐ : ☐☐ NO SABE.....9999	
102	Is there a trained health provider present (assigned) at the facility at all times (24 hours/day) for emergencies?	YES, TRAINED PROVIDER ALWAYS PRESENT .....1 NO,.....2	➔104
103	Is there a trained health provider available away from the facility but officially on call at all times after hours? IF YES, ASK TO SEE ON-CALL DUTY SCHEDULE.	YES, SCHEDULE SEEN .....1 YES, SCHEDULE NOT SEEN.....2 NO.....3	

104	Now I have some questions about the staff who provide <u>outpatient</u> services or provide community based services. We want to know the <u>highest technical qualification</u> and the number of staff who are routinely assigned to outpatient services. This may include staff who also rotate to inpatient services. We want to know their highest technical qualification (e.g. nurse or doctor), regardless of the administrative position or specialist studies after qualification.					
		(1)	(2)	(3)	(4)	
	QUALIFICATION	NUMERO TOTAL	Perma-nentes	Contra-tados	Año de Servicio	
	A) MEDICOS					
	B) ODONTOLOGOS					
	C) ENFERMERAS					
	D) AUXILIARES de ENFERMERIA					
	E) AUXILIARY NURSES					
	E) PARTERAS					
	F) PROMOTORES de SALUD					
	G) INSPECTORES					
	H) EDUCADORES					
	W) OTHER (SPECIFY) _____					
	G) SUM THE NUMBER OF STAFF REPORTED IN 104A-W AND ASK: You have told me that you have ___(number of staff) who provide outpatient or community outreach services. Is this correct? IF NOT CORRECT, PROBE AND CHANGE 104A-W AS NECESSARY.	YES, NUMBER CORRECT .....1 NO 2				
104_a	For the doctors listed above, how many person-equivalents of time are spent on administrative rather than clinical duties?	MEDICOS ADMINISTRATIVOS:				

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
105_a	Do you know the ***official*** size of the catchment population that this facility serves – that is, the size of the population assigned to the establishment by MSPAS or the SIBASI? IF YES: How many people is that?	OFFICIAL POPULATION [ ][ ][ ][ ][ ][ ][ ] NO CATCHMENT AREA ... 9999995 DON'T KNOW OFFICIAL CATCHMENT POPULATION 9999998	➔106 ➔106
105_b	Does the ***actual*** size of the catchment population differ from the official population – that is, does the population living in the area served by this facility differ substantially from the official estimate used for planning? IF YES: What is your estimate of the actual catchment population?	ACTUAL POPULATION [ ][ ][ ][ ][ ][ ][ ] NO DIFFERENCE 0	
106	Does this facility routinely admit inpatients for treatment?	YES ..... 1 NO 2	
107	Does this facility have beds for overnight observation?	YES ..... 1 NO 2	➔107_b
107_a	How many beds does this facility have?	Beds: [ ][ ][ ]	
107_b	How many consultas externas did this facility plan to see for the period January-June?	CONSULTAS EXTERNAS META: [ ][ ][ ][ ][ ][ ] NO META 99997	
107_c	How many total consultas externas has this facility realized during the period January-June?	CONSULTAS EXTERNAS REALIZADA: [ ][ ][ ][ ][ ][ ] DON'T KNOW 99998	➔108
107_d	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED	No. Months: [ ][ ]	
108	Does this facility have routine meetings for reviewing management or administrative issues?	YES ..... 1 NO ..... 2 DON'T KNOW 8	 ➔111 ➔111
109	How often do meetings to discuss the facility management/administrative issues take place?	MONTHLY ..... 1 QUARTERLY ..... 2 SEMIANNUALLY ..... 3 OTHER_____ ... 6	
110	Is an official record of meetings maintained? IF YES, ASK TO SEE SOME RECORD (MINUTES/NOTES) FROM THE MOST RECENT MEETING.	YES, RECORD OBSERVED ..... 1 YES, REPORTED, NOT SEEN ..... 2 NO RECORD MAINTAINED 3	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
111	Are there any routine meetings about facility activities or management issues that include both facility staff and community members?	YES .....1 NO .....2 DON'T KNOW 8	
112	Does this facility have any system for determining client opinion about the health facility or services? IF YES, CIRCLE ALL METHODS FOR ELICITING CLIENT OPINIONS THAT ARE USED.	SUGGESTION BOX.....A CLIENT SURVEY FORM .....B CLIENT INTERVIEW..... C OTHER _____..... W (SPECIFY) NO CLIENT FEEDBACK.....Y DON'T KNOW .....Z	 ➔115 ➔115
113	Is there a procedure for reporting on clients' opinions? IF YES, ASK TO SEE A REPORT OR FORM WHERE DATA IS COMPILED.	YES, REPORT SEEN .....1 YES, NO REPORT SEEN.....2 NO 3	
114	In the past 3 months, have any changes been made in the program as a result of client opinion? IF YES, DESCRIBE THE CHANGES MADE. _____ _____	YES, _____ 1 (SPECIFY) NO .....2 DON'T KNOW 8	
115	Does this facility monitor quality of care? This refers to a routine program for quality assurance.	YES .....1 NO .....2 DON'T KNOW 8	 ➔119 ➔119
116	Is this system implemented throughout the facility, or is it within specific services only?	THROUGHOUT FACILITY.....1 ONLY SPECIFIC SERVICES.....2	

117 Are any of the following methods for quality assurance used? IF YES, ASK TO SEE SOME DOCUMENTATION (REPORT/MINUTES/ETC.) FOR THE METHOD IMPLEMENTATION.

FOR EACH SYSTEM FOR QUALITY ASSURANCE LISTED, INDICATE IF THE METHOD IS USED, AND IF DOCUMENTATION FOR THE SYSTEM USAGE WAS OBSERVED	1=YES, OBSERVED 2=YES, REPORTED AVAILABLE 3=METHOD NOT USED 8=NOT DETERMINED			
A) Supervisory checklist for health system components (e.g., service specific equipment, meds, and records)	1	2	3	8
B) Supervisory checklist for health service provision (e.g. observation checklist)	1	2	3	8
C) System for identifying and addressing quality of care that is implemented by staff or specific service level (e.g., not carried out facilitywide)	1	2	3	8
D) Facilitywide review of mortality	1	2	3	8
E) Periodic audit of medical records or service registers	1	2	3	8
F) Quality assurance committee or team	1	2	3	8

	G) Regional or district health management teams	1	2	3		8
	W) Other (SPECIFY) _____ _____	1	2	3		8
118	Who is responsible for reviewing findings and taking action from quality assurance activities? FOR EACH OF THE LISTED OPTIONS, INDICATE IF THE PERSONS ARE POSTED INTERNAL, FROM OUTSIDE THE FACILTIY, OR BOTH	1=INTERNAL TO FACILITY 2=EXTERNAL TO FACILITY 3= BOTH INTERNAL AND EXTERNAL 4=NOT ACTIVE WITH QUALITY ASSURANCE 8=DON'T KNOW				
	A) Individual service provision staff.....	1	2	3	4	8
	B) Individual supervisors.....	1	2	3	4	8
	C) Management committee	1	2	3	4	8
	D) Special quality assurance committee or team	1	2	3	4	8
	E) Special quality assurance staff.....	1	2	3	4	8
	F) Regional or district management team	1	2	3	4	8
	W) Other _____	1	2	3	4	8

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
118_a	Quien está encargado de supervisar los promotores de salud del establecimiento?	Supervisor de Promotores ..... 1 Director del Establecimiento ..... 2 Medico..... 3 Enfermera ..... 4 Otro _____ ..... 5 (Especifica) No hay supervisión activa ..... 8 No hay promotores 9	 ➔124 ➔124
118_b	Con cual frecuencia (en meses) hacen expedientes de los promotores de salud?	Frequencia de supervision de promotores Meses: ☐☐	
122	When was the last time a supervisor from outside this facility visited the facility?	WITHIN THE PAST 6 MONTHS.... 1 MORE THAN 6 MONTHS AGO.... 2 NEVER SUPERVISED FROM OUTSIDE FACILITY 3	 ➔124 ➔124
122_a	Was the supervisor from the SIBASI, Equipo Tecnico de Zona, or the Ministry?	SIBASI..... 1 EQUIPO de ZONA ..... 2 MINISTERIO 3	

123	The most recent time within the past 6 months that a supervisor from outside the facility visited, did the supervisor:		YES	NO	DK
	A) Check some registers/books?	CHECKED REGISTERS	1	2	8
	B) Discuss problems?	DISCUSSED PROBLEMS	1	2	8
	C) Discuss policy/administrative issues?	DISCUSSED POLICY	1	2	8
	D) Discuss technical protocols or issues related to service delivery practices?	DISCUSSED TECHNICAL MATTERS	1	2	8
	E) Hold an official staff meeting?	HELD STAFF MEETING	1	2	8
	F) Observe individual staff providing services?	OBSERVED SERVICE PROVISION	1	2	8
	W) Do anything else?	OTHER_____ (SPECIFY)	1	2	8
124	Is there a standard form used for clients referred to other facilities? ASK TO SEE THE FORM. (IF THE FACILITY IS THE REFERRAL FACILITY, THEN CIRCLE "4" FOR REFERRAL FACILITY.)	YES, FORM SEEN ..... 1 YES, FORM NOT SEEN ..... 2 NO FORM USED ..... 3 REFERRAL FACILITY ..... 4 DON'T KNOW 8			 ➔126 ➔126 ➔126

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
125	Does the referral form have a section requiring client information explaining the reason for the referral?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
126	Does this facility ever have electricity from a source other than a backup generator?	YES, CENTRAL SUPPLY ..... 1 YES, SOLAR OR OTHER SOURCE ..... 2 NO 3	 ➔128
127	Is the electricity (do not include backup generator support) always available during the times when the facility is providing services, or is it sometimes interrupted? IF SOMETIMES INTERRUPTED, ASK, On how many <u>days</u> during the past week was the electricity <u>not available for two (2) or more hours?</u>	ALWAYS AVAILABLE ..... 0 # OF DAYS <u>NOT AVAILABLE</u> PAST WEEK	
128	What is the <u>most commonly used</u> source of water for the facility <u>at this time</u>?	PIPED FROM PROTECTED SOURCE OFFSITE ..... 10 PIPED FROM OFFSITE UNPROTECTED SOURCE ..... 11 PIPED FROM OFFSITE, SOURCE UNKNOWN ..... 12 PROTECTED WELL/ BOREHOLE ..... 20 UNPROTECTED WELL/ BOREHOLE ..... 21 RIVER/LAKE /POND ..... 30 OTHER_____ (SPECIFY) . 96 NO WATER SOURCE 00	 ➔132
133_a	Does this facility have a working telephone for calling outside?	YES ..... 1 NO 2	

133_b	Does this facility have a working shortwave radio for calling outside?	YES ..... 1 NO 2	
133_c	Does this facility have a working computer?	YES ..... 1 NO 2	➔133_e
133_d	How many computers does this facility have?	No. Computers: ☐☐	
133_e	Does this facility have an ambulance (operative or inoperative)?	YES ..... 1 NO 2	➔133_g
133_f	How many functioning ambulances does this facility have? How many inoperative ambulances does this facility have?	Functioning ambulances: ☐ Inoperative ambulances: ☐	
133_g	Does this facility have any vehicle (operative or inoperative), excluding ambulances?	YES ..... 1 NO 2	➔133_i
133_h	How many functioning vehicles does this facility have? How many inoperative vehicles does this facility have?	Functioning vehicles: ☐☐ Inoperative vehicles: ☐☐	
NO.	**QUESTIONS**	**CODE CLASSIFICATION**	**GO TO**
133_i	Does this facility have any motorcycles (operative or inoperative)?	YES ..... 1 NO 2	➔135
133_j	How many functioning motorcycles does this facility have? How many inoperative motorcycles does this facility have?	Functioning motorcycles: ☐☐ Inoperative motorcycles: ☐☐	
135	Does this facility have a program for routine <u>preventive</u> maintenance for major equipment such as a generator, refrigerator, or sterilizing equipment? IF YES: Who is responsible for the maintenance?	YES, ONSITE STAFF ..... 1 YES, OUTSIDE SUPPORT ..... 2 YES, BOTH ..... 3 NO ROUTINE MAINTENANCE ..... 4 DON'T KNOW 8	
136	What is the system for repairing or replacing small equipment (blood pressure cuffs, stethoscope, etc.) (CIRCLE ALL THAT APPLY).	ONSITE MAINTENANCE ..... A PETTY CASH FOR REPLACING .. B SEND ELSEWHERE FOR REPAIR ..... C OTHER _____ ..... W (SPECIFY) NO SYSTEM ..... Y DON'T KNOW ..... Z	
149	Does this facility have a backup generator? IF YES, ASK TO SEE THE GENERATOR.	YES, OBSERVED 1 YES, NOT OBSERVED ..... 2 NOT AVAILABLE ..... 3 NOT DETERMINED 4	
150	Is the generator functional and is there fuel present today?	YES, FUNCTIONAL W/ FUEL 1 YES, FUNCTIONAL, NO FUEL 2 NOT FUNCTIONAL 3 NOT DETERMINED 8	

151	How does this facility dispose of potentially contaminated waste and items that are not reused (e.g., bandages, syringes)?	BURNED IN INCINERATOR ..... 1 BURNED IN OPEN PIT ..... 2 BURNED AND BURIED..... 3 THROWN IN TRASH/OPEN PIT ... 4 THROWN IN PIT LATRINE ..... 5 OTHER_____ 6	
152	INTERVIEWER: ASK TO SEE PLACE USED FOR WASTE DISPOSAL.	WASTE VISIBLE, NOT PROTECTED ..... 1 WASTE VISIBLE,PROTECTED .... 2 NO WASTE VISIBLE ..... 3 WASTE SITE NOT INSPECTED... 8	
153	Is there a waiting area for clients where they are protected from sun and rain?	YES ..... 1 NO 2	
154	Is there a toilet (latrine) in functioning condition that is available for use of clients?	YES ..... 1 NO 2	
155	ASSESS GENERAL CONDITION OF THE FACILITY AND INDICATE IF ANY OF THE ITEMS LISTED WERE NOTED	BROKEN WINDOWS.....A BROKEN DOORS.....B BROKEN WALLS.....C LEAKING PLUMBING.....D OTHER_____ .....W (SPECIFY) NO MAJOR PROBLEMS .....Z	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
156	ASSESS GENERAL CLEANLINESS OF FACILITY ■ A FACILITY IS CLEAN IF THE FLOORS ARE SWEPT AND COUNTERS/TABLES ARE WIPED AND FREE FROM OBVIOUS DIRT OR WASTE. ■ A FACILITY IS NOT CLEAN IF OBVIOUS DIRT/WASTE/BROKEN OBJECTS ARE ON THE FLOORS OR COUNTERS.	FACILITY CLEAN ..... 1 FACILITY NOT CLEAN..... 2	
160_a	Does this facility obtain or receive fondos from any source other than MSPAS? Only monetary support should be included; drugs, labor support, etc. should not be included here.	Mark all sources apply: FUNDS FROM LOCAL GOV .....A FUNDS FROM DONORS .....B EXTERNAL LOAN .....C CUOTAS VOLUNTARIAS.....D OTHER _____ .....W (SPECIFY) NO ..... 7 DON'T KNOW 8	

161_a Does this facility have a system in place to track any monetary expenditures?

YES 1
NO ..... 2 ➔164_a
DON'T KNOW ..... 8 ➔164_a

If yes, please specify:

_____

_____

162_a Who assures that all transactions are entered and that calculations are correct?

_____

_____

163_a When was the last time a supervisor from outside this facility assured that all transactions and calculations were correct?

WITHIN THE PAST 6 MONTHS 1
MORE THAN 6 MONTHS AGO 2
NEVER SUPERVISED FROM OUTSIDE FACILITY 3

Before beginning the questions related to specific services, we would like to ask three brief questions related to the recent SIBASI reforms. These answers may be used in the final report, but will not be attributed to a particular SIBASI, facility, or person.

164_a While the MSPAS has set out a vision of how SIBASIs should operate, SIBASIs are actually at very different degrees of development. What do you perceive to be the main changes that have occurred since this SIBASI was established?

_____

_____

_____

_____

_____

_____

_____

165_a Can you explain to me what you understand to be the concept of a SIBASI? How clear is this concept to you?

_____

_____

_____

_____

_____

_____

_____

166_a What is the mission (or purpose) of the SIBASI? How does that mission guide your work?

_____

_____

_____

_____

_____

_____

_____

2a. VACCINE LOGISTIC SYSTEM

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
200	Now I would like to find out information about immunization services provided to children or pregnant women either by or at your facility. Are any immunization services provided either as outreach or at the facility? IF YES, ASK WHO RECEIVES IMMUNIZATIONS, AND CIRCLE THE APPROPRIATE RESPONSE.	YES, CHILDREN ONLY .....1 YES, PREGNANT WOMEN ONLY.....2 BOTH CHILDREN AND PREGNANT WOMEN .....3 NO IMMUNIZATION SERVICES EVER PROVIDED.....4	 →250
201	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN MANAGEMENT OF IMMUNIZATION SERVICES. IF DIFFERENT FROM INDIVIDUALS RESPONDING PREVIOUSLY, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 201. **READ TO CHILD HEALTH SERVICES INFORMANT (IF DIFFERENT FROM INFORMANT FOR PREVIOUS SECTIONS)** Hello. I am representing the PHRplus, a USAID project. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences with the system for providing vaccine services. Please be assured that the information is completely anonymous. You may choose to stop the interview at any time. Do you have any questions for me? Do I have your agreement to participate? _____ INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate) _____ DATE		
202	May I begin the interview?	YES .....1 NO 2	 →STOP
203	Does this facility routinely store <u>any</u> vaccines or are all vaccines either picked up from another facility or delivered when providing services?	STORES SOME VACCINES.....1 STORES NO VACCINES.....2	 →213
204	ASK TO GO WHERE VACCINES ARE STORED AND EXPLAIN. I want to find out about your system for keeping vaccines. What type of equipment do you use to store your vaccines?	REFRIGERATOR.....1 COLD BOX.....2	
205	INTERVIEWER: INDICATE THE TEMPERATURE INSIDE THE FRIDGE OR COLD BOX.	TEMPERATURE CENTIGRADE ☐☐ NOT OBSERVED.....88 THERMOMETER NOT FUNCTIONING.....86 NO THERMOMETER.....99	 →210 →210 →210
206	TEMPERATURE ABOVE OR BELOW 0 DEGREES (FOR "0" DEGREES INDICATE "1" FOR POSITIVE.	POSITIVE +.....1 NEGATIVE -.....2	
207	INDICATE IF THE FRIDGE OR COLD BOX IS PROTECTED FROM DIRECT SUNLIGHT	YES .....1 NO .....2 DON'T KNOW 8	
208	Do you have a cold chain temperature-monitoring chart? IF YES: may I see it?	YES, SEEN .....1 YES, NOT SEEN.....2 NO 3	 →210 →210

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
209	INTERVIEWER: CHECK THAT THE TEMPERATURE RECORD IS COMPLETED TWICE DAILY FOR EACH OF THE PAST 30 DAYS.	YES, COMPLETED .....1 NO, NOT COMPLETED 2	
210	Is there an inventory for the vaccines? IF YES, ASK TO SEE IT. (IF THERE IS NO INVENTORY, ALL RESPONSES FOR (c) IN 211 ARE "8" FOR NOT DETERMINED.)	YES, OBSERVED .....1 YES, NOT SEEN .....2 NO INVENTORY 3	

ASK TO SEE THE VACCINES. FOR ALL ITEMS CHECK FOR THE FOLLOWING:
1) ARE THEY PRESENT? IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. (2) INQUIRE IF THE VACCINE HAS STOCKED OUT FROM THE ***PHARMACY*** IN THE LAST SIX MONTHS. FOR EACH VACCINE, CIRCLE THE APPROPRIATE CODE FOR PART (A) and (B).

211 VACCINE	(A) OBSERVED W/EXPIRY DATE 1=AT LEAST ONE VALID 2=REPORTED AVAILABLE 3=STOCKED OUT 7=SERVICE NOT PROVIDED 8=NOT DETERMINED	(B) ***PHARMACY*** HAS STOCKED OUT IN THE LAST SIX MONTHS 1=YES or CURRENTLY ABSENT 2=NO 7=SERVICE NOT PROVIDED 8=DON'T KNOW
a) Tetanus toxoid	1 2 3 7 8	1 2 3 8
b) BCG	1 2 3 7 8	1 2 3 8
c) Oral polio (OPV)	1 2 3 7 8	1 2 3 8
d) Pentavalente	1 2 3 7 8	1 2 3 8
e) SPR (MMR)	1 2 3 7 8	1 2 3 8
f) Hepatitis B	1 2 3 7 8	1 2 3 8

213	Does this facility determine the amount of vaccines required and order this amount, or is the amount that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS.....1 NEED DETERMINED ELSEWHERE.....2 DON'T KNOW 8	→215
214	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the quantity you receive vary with the activity level that you report?	QUANTITY BASED ON ACTIVITY LEVEL .....1 STANDARD FIXED SUPPLY.....2 DON'T KNOW 8	→217 →217 →217
215	How do you decide how much of each vaccine to order ? (IF UNCERTAIN, ASK QUESTIONS TO CLARIFY WHICH RESPONSE(S) MOST CLOSELY DESCRIBE THE SYSTEM(S) USED) A) ORDER TO BRING STOCK TO FIXED LEVEL B) ORDER THE SAME QUANTITY EACH TIME REGARDLESS OF HOW MUCH OF EACH VACCINE REMAINS IN STOCK C) ORDER DIFFERENT AMOUNTS BASED ON CALCULATIONS OF PRIOR UTILIZATION AND EXPECTED FUTURE ACTIVITY D) ORDER DEPENDING ON WHAT STAFF THINK IS NEEDED, WITHOUT A SPECIFIC METHOD FOR CALCULATING AMOUNTS W) OTHER (SPECIFY)_____ Z) DON'T KNOW	.....A .....B ..... C ..... D .....W .....Z	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
216	How do you decide when to order vaccines? (IF UNCERTAIN, ASK QUESTIONS TO CLARIFY WHICH RESPONSE(S) MOST CLOSELY DESCRIBE THE SYSTEM(S) USED.) A) PLACE AN ORDER WHENEVER STOCK LEVELS FALL TO A PREDETERMINED LEVEL B) THERE IS A FIXED TIME WHEN STAFF ARE SUPPOSED TO SUBMIT ORDERS FOR VACCINES. IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. C) THE FACILITY CAN PLACE AN ORDER WHENEVER THERE IS BELIEVED TO BE A NEED, REGARDLESS OF STOCK LEVEL. W) OTHER (SPECIFY)_____ Z) DON'T KNOW	.....A .....B EVERY ☐☐ WEEKS ..... C .....W .....Z	
217	**During the past 3 months**, have you always, sometimes or almost never received the amount of vaccines that you order (or that you are supposed to routinely receive)?	ALWAYS ..... SOMETIMES ..... ALMOST NEVER.....	

Section 2b. Child Health Services

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
250	Does this facility provide any services for children below 5 years of age, either at the facility or on an outreach basis?	YES ..... 1 NO 2	➔300

251 FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF CHILD CURATIVE HEALTH SERVICES. IF DIFFERENT FROM THE INDIVIDUAL RESPONDING PREVIOUSLY, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 220.

READ TO CHILD HEALTH SERVICES INFORMANT (IF DIFFERENT FROM PREVIOUS INFORMANT):

Hello. I am representing the PHRplus, a USAID project. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely anonymous. You may choose to stop the interview at any time.

Do you have any questions for me? Do I have your agreement to participate?

_____ _____
INTERVIEWER'S SIGNATURE DATE
(Indicates respondent's willingness to participate)

252	May I begin the interview?	YES ..... 1 NO 2	➔300

253 Now, I would like to ask you specifically about child health services. For each of the following services please tell me if the service is offered by your facility, and if yes, how many days per month is the service provided <u>at the facility?</u>

CHILD HEALTH SERVICE (use a 4-week month to calculate number of days) 95=SERVICE NOT OFFERED	(a) # Days per month service provided <u>at facility</u>	(b) # Days per month service provided through outreach (village level) activities
A) Consultation/curative services for the sick child.	# DAYS ☐☐	# DAYS ☐☐
B) Growth monitoring or growth promotion (where the <u>healthy child</u> is routinely weighed and weight is charted on growth chart and feeding advice given.)	# DAYS ☐☐	# DAYS ☐☐
C) Routine series of immunizations for children (DPT, POLIO, MEASLES).	# DAYS ☐☐	# DAYS ☐☐
D) BCG immunizations.	# DAYS ☐☐	# DAYS ☐☐

254	CHECK 253C (a) AND INDICATE IF ROUTINE CHILD IMMUNIZATIONS ARE EVER PROVIDED AT THE FACILITY.	YES ..... 1 NO 2	➔263
255	Are routine child immunizations available at the facility today?	YES, ... 1 NO 2	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
256	Does this facility routinely charge for any vaccination services? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED.	YES, FIXED FEE FOR EPI CARD ...A YES, FIXED FEE FOR VACCINE SESSION .....B YES, VARIABLE FEE PER VACCINE ..... C OTHER _____ .....W (SPECIFY NO CHARGES .....Y DON'T KNOW .....Z	
259	What is the current estimate for your Pentavalente dropout rate?	PENTAVALENTE DROPOUT RATE (%) ..... ☐☐☐ DON'T KNOW 998	
259_a	How many total Pentavalente vaccines did this facility plan to provide (META) for the period January-June.	PENTAVALENTE META: ☐☐☐☐☐ NO META.....99997	
259_b	How many total Pentavalente vaccines has this facility realized during the period January-June?	PENTAVALENTE REALIZADA: ☐☐☐☐☐ DON'T KNOW 99998	➔259_d
259_c	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED	MONTHS OF DATA: ☐☐	
259_d	How many total Pentavalente3 vaccines (just third dosis) has this facility realized for the period January-June?	PENTAVALENTE2 REALIZADA: ☐☐☐☐☐	
259_e	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED	No. Months: ☐☐	
260	Do you have an estimate of the total number of the target population for child immunizations in the facility catchment area? IF YES: How many children is that?	TARGET POPU-LATION: ☐☐☐☐☐ NO CATCHMENT AREA .....00000 DON'T KNOW TARGET POPULATION SIZE 99998	➔263 ➔263
261	What is the current estimate for your MMR coverage?	MMR COVERAGE (%) ..... ☐☐☐ DON'T KNOW 998	
262	RECORD THE SOURCE(S) OF INFORMATION FOR % COVERAGE AND DROPOUT RATE ESTIMATES	WRITTEN REPORT.....A WALL GRAPH .....B OTHER _____ .....W (SPECIFY) NO COVERAGE RATES .....Y SOURCE NOT KNOWN .....Z	

263_a	How many total visits for children under one year (new and follow up) did this facility plan to see for the period January-June.	< 1 Year Olds META ☐☐☐☐☐ NO META 99997	
263_b	How many total visits for children under one year (new and follow up) took place during the January-June period?	NUMBER OF < 1 YEAR OLD VISITS ☐☐☐☐☐ DON'T KNOW 99998	➔420
263_c	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA ..... ☐☐	
264_a	How many total visits for children one to four years (new and follow up) did this facility plan to see for the period January-June.	1-4 Year Olds META ☐☐☐☐☐ NO META 99997	
264_b	How many total visits for children one to four years (new and follow up) took place during the January-June period?	NUMBER OF 1-4 Year Olds VISITS ☐☐☐☐☐ DON'T KNOW 99998	➔420
264_c	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA ..... ☐☐	
265_a	Do you submit an official report externally (usually to the MoH or a public health agency) that indicates the number of cases of childhood (0-4 years) diarrhea?	YES, ...1 NO 2	
266_a	RECORD THE NUMBER OF CHILDHOOD (0-4 years) DIARRHEA CASES DURING THE JANUARY-JUNE PERIOD	NUMBER OF DIARRHEA CASES IN 0-4 YEARS . ☐☐☐☐	
266_b	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED.	DON'T KNOW .....9998 MONTHS OF DATA ..... ☐☐	

Section 3. Family Planning Services

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
	300 OMITTED		
301	Does this facility offer any other family planning services? This includes clinical methods or counseling on natural family planning.	YES ..... 1 NO 2	➔400
302	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF FAMILY PLANNING SERVICES. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 302. **READ TO FAMILY PLANNING SERVICES INFORMANT (IF DIFFERENT FROM INFORMANT FOR PREVIOUS SECTIONS):** Hello. I am representing the PHRplus, a USAID project. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely anonymous. You may choose to stop the interview at any time. Do you have any questions for me? Do I have your agreement to participate? _____ _____ INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate) DATE		
303	May I begin the interview?	YES ..... 1 NO 2	➔400
304	How many days in a week are family planning services provided at the facility?	# DAYS ..... ☐	
305	Are family planning services being provided today?	YES..... 1 NO 2	
306	Does this facility routinely charge for any family planning consultation services? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED	YES, FIXED FEE FOR FP CARD.. A YES, FIXED CONSULT FEE ..... B YES, CONSULT FEE VARIES BY METHOD..... C YES, CHARGE FOR METHOD/ LAB TESTS..... D OTHER _____ ..... W (SPECIFY) NO..... Y DON'T KNOW..... Z	

307	Which of the following methods of contraception is provided at this facility?	YES	NO	DON'T KNOW	
	A) Pastillas	1	2	8	
	C) T de Cobre	1	2	8	
	D) Inyección	1	2	8	
	F) NORPLANT	1	2	8	
	G) Condones.....	1	2	8	
	H) Condones femeninas	1	2	8	
	I) Espermicidas	1	2	8	
	J) Diafragma.....	1	2	8	
	K) Esterilización feminina (ligadura)	1	2	8	
	H) Esterilización masculina	1	2	8	
	l) Consejeria sobre metodos naturales de planificación familiar	1	2	8	

NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
310	ASK TO SEE WHERE COUNSELING FOR FAMILY PLANNING IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM .....1 ROOM WITH OTHER PEOPLE W/SEPARATING BARRIER 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER.....3	
311	Are any of the following visual aids for teaching available, in the counseling or the examination room?	1=OBSERVED ACTIVITY 2=ACTIVITY REPORTED 3=ACTIVITY NOT ROUTINELY CONDUCTED 8=NOT DETERMINED	
	A) Different family planning methods	1 2 3 8	
	B) Visual aids for teaching about STIs	1 2 3 8	
	C) Visual aids for teaching about HIV/AIDS	1 2 3 8	
	D) Model for demonstrating use of condoms	1 2 3 8	
	E) Posters on family planning	1 2 3 8	
312	Are any of the following information booklet/pamphlet for client to take home available in the counseling or the examination room?		
	A) On family planning	1 2 3 8	
	B) On STIs	1 2 3 8	
	C) On HIV/AIDS	1 2 3 8	
314	Is there a register where family planning consultation information is recorded? IF YES, ASK TO SEE THE REGISTER. REGISTER MUST HAVE METHOD AND NEW/CONTINUING STATUS INDICATED FOR EACH CLIENT TO BE VALID.	YES, REGISTER SEEN.....1 YES, REGISTER NOT SEEN .....2 NO REGISTER KEPT 3	 ➔316 ➔316
315	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS .....1 > 7 DAYS.....2	
316	How many <u>total</u> (new and continuing) family planning clients did this facility plan to see for the period January-June.	FAMILY PLANNING META ☐☐☐☐☐ NO META 99997	
316_a	How many <u>total</u> clients (new and continuing) received family planning services did the during the January-June period?	NUMBER OF FP CLIENTS ☐☐☐☐☐ DON'T KNOW 99998	 ➔318
317	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA..... ☐☐	
318	Are individual client cards/records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD.	YES, OBSERVED CARD .....1 YES, CARD NOT SEEN.....2 NO INDIVIDUAL CARDS 3	
319	Does the family planning provider routinely treat STIs or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STIS.....1 REFERS TO OTHER PROVIDER/ LOCATION .....2 NO TREATMENT PROVIDED 3	

Section 4a. Antenatal and Postpartum Care

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
400	Does this facility offer antenatal and/or postpartum services? Indicate the services provided from this facility.	YES, ANTENATAL ..... A YES, POSTPARTUM ..... B NO, NEITHER SERVICE ..... Y	➔440
401	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF ANTENATAL CARE. IF DIFFERENT FROM THE INDIVIDUAL RESPONDING TO EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 403. **READ TO ANTENATAL HEALTH SERVICES INFORMANT (IF DIFFERENT FROM INFORMANT FOR PREVIOUS SECTIONS):** Hello. I am representing the PHRplus, a USAID project. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely anonymous. You may choose to stop the interview at any time. Do you have any questions for me? Do I have your agreement to participate? _____ INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate) _____ DATE		
402	May I begin the interview?	YES ..... 1 NO 2	➔STOP
403	How many days in a week are antenatal care services provided at the facility?	# DAYS..... ☐	
404	Are antenatal care services being provided at the facility today?	YES ..... 1 NO 2	
405_a	Does this facility routinely charge for antenatal care consultation? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED.	YES, FIXED FEE FOR ANC/ HEALTH CARD ..... A YES, FIXED FEE EACH CONSULT..... B YES, FIXED FEE FOR ALL ANC SERVICES ..... C YES, CHARGE FOR MEDICATIONS/TESTS ..... D OTHER _____ .... W (SPECIFY) NO..... Y DON'T KNOW.....Z	

NO.	QUESTIONS	CODING CLASSIFICATION			GO TO
	ASK ABOUT THE FOLLOWING TESTS AND SERVICES AS ROUTINE COMPONENTS OF ANC				
408	LABORATORY TESTS	YES	NO	DON'T KNOW	
	A) Test blood for anemia?	1	2	8	
	B) Test blood for syphilis?	1	2	8	
	C) Test urine for protein?	1	2	8	
409	TREATMENT AND SERVICES FOR ANC CLIENTS				
	A) Are tetanus toxoid vaccination services available each day ANC services are provided?	1	2	8	
	B) Is preventive antimalarial medication routinely provided?	1	2	8	
	C) Are clients routinely counseled about family planning?	1	2	8	
	D) Does the facility routinely offer to provide voluntary counseling and testing for HIV/AIDS?	1	2	8	
410	How many days each week are tetanus toxoid vaccinations offered at this facility?	DAYS PER WEEK ☐ NEVER OFFERED ..... 0 DON'T KNOW 8			➔411
410_a	What is the current estimate for your TT2 coverage amongst pregnant women?	TT2 COVERAGE (%) ..... ☐☐☐ DON'T KNOW 998			
410_b	RECORD THE SOURCE(S) OF INFORMATION FOR % TT2 COVERAGE ESTIMATE	WRITTEN REPORT ..... A WALL GRAPH ..... B OTHER _____ ..... W (SPECIFY) NO COVERAGE RATES ..... Y SOURCE NOT KNOWN ..... Z			
410_c	How many total tetanus toxoid vaccines did this facility plan to provide to pregnant women (META) for the period January-June.	TT META FOR PREGNANT WOMEN: ☐☐☐☐☐ NO META 99997			
410_d	How many total Pentavalente vaccines has this facility realized during the period January-June?	TT REALIZADA FOR PREGNANT WOMEN: ☐☐☐☐☐ DON'T KNOW 99998			➔411
410_e	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED	MONTHS OF DATA: ☐☐			
410_f	How many total TT2 vaccines (just second dosis) has this facility realized for pregnant women during the period January-June?	TT2 REALIZADA: ☐☐☐☐☐ DON'T KNOW 99998			
410_g	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED	No. Months: ☐☐			

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
411	Does the ANC provider(s) routinely treat STIs or are clients referred to another provider or location for STI treatment?	ROUTINELY TREATS STI ..... 1 REFERS ..... 2 NO TREATMENT PROVIDED 3	
412	Is there a register where client information from ANC visits is recorded? IF YES, ASK TO SEE REGISTER. ANC STATUS (1ST VISIT OR FOLLOW UP) MUST BE INDICATED FOR THE REGISTER TO BE VALID.	YES, REGISTER SEEN ..... 1 YES, REGISTER NOT SEEN ..... 2 NO REGISTER KEPT 3	 ➔414 ➔414
413	How recent is the date of the most recent entry for ANC?	WITHIN THE PAST 7 DAYS ..... 1 > 7 DAYS..... 2	
414_a	How many antenatal visits (new and follow up) did this facility plan to see for the period January-June.	ANC META [ ][ ][ ][ ][ ] NO META 99997	
414_b	How many antenatal visits (new and follow up) took place during the January-June period?	NUMBER OF ANC VISITS [ ][ ][ ][ ][ ] DON'T KNOW 99998	 ➔416
415	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA ..... [ ][ ]	
416	Is there a register where client information from postpartum (PP) visits is recorded? IF YES, ASK TO SEE REGISTER. DAYS PP AND INDICATION OF COMPLICATIONS OR NOT MUST BE INDICATED FOR THE REGISTER TO BE VALID.	YES, REGISTER SEEN ..... 1 YES, REGISTER NOT SEEN ..... 2 NO REGISTER KEPT 3	 ➔418 ➔418
417	How recent is the date of the most recent entry for postpartum care?	WITHIN THE PAST 7 DAYS ..... 1 > 7 DAYS..... 2	
418_a	How many postpartum visits (new and follow up) did this facility plan to see for the period January-June?	PP META [ ][ ][ ][ ][ ] NO META 99997	
418_b	How many postpartum visits (new and follow up) took place during the January-June period?	NUMBER OF PP VISITS [ ][ ][ ][ ][ ] DON'T KNOW 99998	 ➔420
419	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA ..... [ ][ ]	
420	Do you have an estimate of the annual number of deliveries (births) in the facility's catchment area?	NUMBER OF BIRTHS ..... [ ][ ][ ][ ][ ] DON'T KNOW ..... 99998 NO CATCHMENT AREA..... 00000	 ➔423 ➔423
421	What is the estimated annual antenatal coverage rate for this facility?	ANC % COVERAGE .... [ ][ ][ ] DON'T KNOW 998	 ➔423

422	RECORD THE SOURCE OF INFORMATION FOR % ANTENATAL COVERAGE ESTIMATES	WRITTEN REPORT ..... A WALL GRAPH ..... B OTHER _____ ..... W (SPECIFY) NOT KNOWN ..... Z	
423	Are individual ANC cards/records maintained? IF YES, ASK TO SEE A BLANK CARD/RECORD?	YES, OBSERVED BLANK CARD .....1 YES, NO BLANK CARD OBSERVED.....2 NO INDIVIDUAL CARDS 3	
432	What is the <u>most common</u> means by which women are transported from home to this facility for help during obstetric emergencies? IF MORE THAN ONE MOST COMMON MEANS, CIRCLE ALL THAT APPLY.	PEOPLE CARRY .....A ANIMAL-DRAWN VEHICLE.....B MOTOR VEHICLE..... C COMBINATION OF ABOVE..... D NO DELIVERY CASES EVER COME TO FACILITY.....E OTHER _____ .....W (SPECIFY) DON'T KNOW .....Z	→500
433	Does this facility have a procedure for transporting women to another facility if necessary in an obstetric emergency? IF THIS IS THE REFERRAL FACILITY, RECORD "3" FOR "REFERRAL FACILITY."	YES .....1 NO .....2 REFERRAL FACILITY .....3 DON'T KNOW 8	 →436 →440 →436
434	FOR EACH OF THE FOLLOWING EMERGENCY TRANSPORTATION PROCEDURES ASK: Does this facility have… AND THEN INDICATE THE STATUS RELATED TO THAT TRANSPORTATION PROCEDURE.	**AVAILABILITY OF METHOD** 1=24 HOURS 2=NORMAL FACILITY HOURS (<24 HR) 3=NO SET TIMES 8=NOT USED	
	A) Emergency vehicle onsite at facility	1 2 3 8	
	B) Multiuse vehicle available at facility that may be used for emergencies.	1 2 3 8	
	C) Call other facility to send emergency vehicle	1 2 3 8	
	D) Rental/hire vehicle arrangement when needed (with facility financial support)	1 2 3 8	
435	Is the vehicle available and operational today? If yes, may I see the vehicle?	YES SEEN/FUNCTIONING ..... … 1 YES SEEN/NOT FUNCTIONING… 2 VEHICLE AWAY FOR EMERGENCY 3 NOT SEEN 4	→437 →437 →437 →437
436	What is the **<u>most common</u>** means by which women are transported from this facility to the nearest referral facility to receive help during an obstetric emergency?	PEOPLE CARRY .....A ANIMAL-DRAWN VEHICLE.....B MOTOR VEHICLE..... C COMBINATION OF ABOVE..... D OTHER _____ .....W DON'T KNOW .....Z	
437	How long does it take, using this form of transportation, to get to the nearest referral facility? (NOTE: IF CALL ELSEWHERE TO OBTAIN VEHICLE, RECORD AVERAGE TIME FROM CALL TO PATIENT ARRIVAL AT REFERRAL FACILITY)	MINUTES ..... ☐☐☐ DON'T KNOW 998	

Section 4b. Delivery and Newborn Care

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
440	Does this facility offer normal delivery services?	YES ..... 1 NO 2	 ➔489
441	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN DELIVERY SERVICES. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO THE EARLIER SECTIONS, INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 432. **READ TO DELIVERY SERVICES INFORMANT (IF DIFFERENT FROM INFORMANT FOR PREVIOUS SECTIONS):** Hello. I am representing the PHRplus, a USAID project. We are carrying out a survey of health facilities that provide services to women and children with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely anonymous. You may choose to stop the interview at any time. Do you have any questions for me? Do I have your agreement to participate? _____ _____ INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate) DATE		
442	May I begin the interview?	YES ..... 1 NO 2	 ➔STOP
443	Does this facility routinely charge for normal deliveries? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED.	YES, FIXED FEE FOR ALL DELIVERY COSTS ..... A YES, FIXED FEE FOR ANC PLUS DELIVERY ..... B YES, CHARGE FOR MEDICATIONS/ TESTS ..... C OTHER _____ ....W (SPECIFY) NO ..... Y DON'T KNOW ..... Z	
444	Is a person skilled in conducting deliveries present at the facility or on call 24 hours a day, including weekends, to provide delivery care?	YES PRESENT ..... 1 YES, ON CALL SCHEDULE SEEN ... 2 YES, ON CALL, NO SCHEDULE SEEN ..... 3 NO 4	
446	Is there a register where client information from attended births is recorded? IF YES, ASK TO SEE REGISTER. BIRTH OUTCOME FOR MOTHER AND INFANT MUST BE INCLUDED TO BE VALID.	YES, REGISTER SEEN ..... 1 YES, REGISTER NOT SEEN ..... 2 NO REGISTER KEPT 3	 ➔448 ➔448
447	How recent is the date of the most recent entry for an attended birth?	WITHIN THE PAST 30 DAYS ..... 1 > 30 DAYS 2	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
448_a	How many deliveries did this facility plan to attend (including trained midwives) during the period January-June.	PARTOS META ☐☐☐☐☐ NO META 99997	
448_b	How many women delivered at this facility or were attended by its trained midwifes during the period January-June?	NUMBER OF PARTOS ☐☐☐☐☐ DON'T KNOW 99998	➔450
449	INDICATE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA..... ☐☐	
450	What percentage of deliveries in your catchment area are conducted by this facility (e.g., your annual coverage rate?)	% COVERAGE ☐☐☐ DON'T KNOW.....998 NO CATCHMENT AREA.....000	➔452 ➔452
451	RECORD THE SOURCE OF INFORMATION FOR DELIVERY COVERAGE ESTIMATE	WRITTEN REPORT .....A WALL GRAPH .....B OTHER _____.....W (SPECIFY) NOT KNOWN .....Z	
452	Do midwives routinely provide home deliveries or attend home delivery emergencies as a part of the facility service?	YES, ROUTINELY..... 1 YES, EMERGENCY ONLY ..... 2 NO 3	➔455
483	Does the facility participate in regular reviews of maternal or newborn deaths or "near miss deaths"?	YES, FOR MOTHERS ..... 1 YES, FOR NEWBORNS..... 2 YES, FOR BOTH ..... 3 NO DO NOT PARTCIPATE..... 4	

Section 5. STI and HIV/AIDS Services

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
500	Does this facility offer any services related to prevention, education, diagnosis, treatment, or supportive services for STIs or HIV/AIDS?	YES .....1 NO 2	 ➔600
501	FIND THE MANAGER OR MOST SENIOR HEALTH WORKER INVOLVED IN THE DELIVERY OF STI/HIV/AIDS SERVICES. IF DIFFERENT FROM INDIVIDUAL(S) RESPONDING TO THE PREVIOUS SECTIONS INTRODUCE YOURSELF AS FOLLOWS. IF THE PERSON IS THE SAME, CONTINUE WITH 502. **READ TO INFORMANT (IF DIFFERENT FROM INFORMANT FOR EARLIER SECTIONS):** Hello. I am representing the PHRplus, a USAID project. We are carrying out a survey of health facilities that provide services for sexually transmitted infections, with the goal of finding ways to improve service delivery. We would be interested in talking to you about this facility and your experiences in providing health services. Please be assured that the information is completely anonymous. You may choose to stop the interview at any time. Do you have any questions for me? Do I have your agreement to participate? _____ INTERVIEWER'S SIGNATURE (Indicates respondent's willingness to participate) _____ DATE		
502	May I begin the interview?	YES .....1 NO 2	 ➔STOP
503	First I want to ask specifically about services for STIs. Does this facility offer STI services?	YES .....1 NO 2	 ➔526
504	Are STI services being offered at the facility today?	YES .....1 NO 2	
505	Are STI services offered in a special clinic or through general outpatient services?	SPECIAL CLINIC.....1 GENERAL OUTPATIENT 2	
506	How many days per week are STI services available in either the special or general clinic?	# DAYS..... ☐	
507	Does this facility routinely charge for STI consultation services? IF YES, CIRCLE ALL ROUTINE CHARGING PRACTICES THAT ARE USED.	YES, FIXED FEE FOR HEALTH CARD .....A YES, FIXED FEE EACH CONSULT .....B YES, CONSULT FEE VARIES BY DIAGNOSIS..... C YES, CHARGE FOR MEDICATIONS/TESTS..... D OTHER _____.... W (SPECIFY) NO .....Y DON'T KNOW .....Z	
509	Does this facility have a protocol regarding confidentiality for STI clients? IF YES, ASK TO SEE A COPY.	YES, OBSERVED ..... 1 YES, NOT OBSERVED..... 2 NO ..... 3 DON'T KNOW 8	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
510	Does the facility normally perform partner notification or follow up? IF YES, Is this ever active (where the facility makes contact with the partners), or is it only passive (where the facility asks the client to inform or bring their partners)?	YES, SOMETIMES ACTIVE..... 1 YES, ONLY PASSIVE ..... 2 NO 3	 ➔512 ➔512
511	Do you have a form/referral form or register where records are kept about clients for active follow up? IF YES, ASK TO SEE.	YES, FORM SEEN..... 1 YES, REGISTER SEEN ..... 2 YES, FORM/REGISTER NOT SEEN ..... 3 NO FORM/REGISTER 4	
512	Is there a register where STI consultation information is recorded? IF YES, ASK TO SEE THE REGISTER. CLIENT NAME, AGE, SEX, AND DIAGNOSIS MUST BE INDICATED FOR REGISTER TO BE VALID.	YES, REGISTER SEEN ..... 1 YES, REGISTER NOT SEEN ..... 2 NO REGISTER KEPT 3	 ➔517 ➔517
513	Does the register indicate a specific type of STI diagnosed?	YES ..... 1 NO 2	
514	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS ..... 1 > 7 DAYS..... 2	
517	Do you submit an official report externally (usually to the MoH or a public health agency) that indicates the numbers and types of STIs diagnosed? IF YES, is the report generated from consultation records or from the laboratory?	YES, CONSULTATION ..... 1 YES, LABORATORY..... 2 YES, BOTH ..... 3 NO 4	
517a 517b	RECORD THE NUMBER OF CLIENTS WHO RECEIVED STI SERVICES DURING THE JANUARY-JUNE PERIOD INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED.	NUMBER OF STI CLIENTS ..... ☐☐☐ DON'T KNOW ..... 998 MONTHS OF DATA ..... ☐☐	
518	ASK TO SEE WHERE COUNSELING FOR CLIENTS WITH SUSPECTED STIS IS PROVIDED AND INDICATE THE SETTING.	PRIVATE ROOM..... 1 ROOM WITH OTHER PEOPLE W/SEPARATING BARRIER..... 2 ROOM WITH OTHER PEOPLE AND NO VISUAL BARRIER..... 3	
519	Are any of the following available in the counseling or the examination room?	1=OBSERVED 2=REPORTED AVAILABLE 3=NOT AVAILABLE 8=NOT DETERMINED	
	VISUAL AIDS FOR TEACHING		
	A) About STIs	1 2 3 8	
	B) About HIV/AIDS	1 2 3 8	
	C) Model for demonstrating use of condoms	1 2 3 8	
	INFORMATION BOOKLET/PAMPHLET FOR CLIENTS TO TAKE HOME		
	D) On STIs	1 2 3 8	
	E) On HIV/AIDS	1 2 3 8	
	F) Are there condoms present in the room?	1 2 3 8	
526	Now I want to ask you specifically about any services related to HIV or AIDS. Does this facility offer any services related to HIV/AIDS?	YES ..... 1 NO 2	 ➔553
527	Does this facility offer voluntary counseling and testing (VCT) for HIV?	YES ..... 1 NO 2	 ➔534

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
528	Are VCT services offered in a special clinic or through general outpatient services?	SPECIAL CLINIC..... 1 GENERAL OUTPATIENT ..... 2 OTHER _____..... 6 (SPECIFY)	
530	Is there a register where VCT client information is recorded? IF YES, ASK TO SEE THE REGISTER. DATE AND RESULT OF TEST SHOULD BE INDICATED FOR THE REGISTER TO BE VALID.	YES, REGISTER SEEN ..... 1 YES, REGISTER NOT SEEN ..... 2 NO REGISTER KEPT 3	 ➔532 ➔532
531	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS ..... 1 > 7 DAYS..... 2	
532	RECORD THE NUMBER OF NEW CLIENTS WHO RECEIVED VCT SERVICES DURING THE JANUARY-JUNE PERIOD.	NUMBER OF HIV CLIENTS ..... ☐☐☐ DON'T KNOW 998	 ➔534
533	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED.	MONTHS OF DATA ..... ☐☐	
534	Does this facility provide any diagnostic, follow up, or treatment for HIV/AIDS, apart from VCT?	YES..... 1 NO 2	 ➔553

535 FOR EACH OF THE FOLLOWING HIV/AIDS-RELATED SERVICES, INDICATE IF THE FACILITY PROVIDES THE SERVICE, REFERS ELSEWHERE, OR DOES NOT PROVIDE THE SERVICE OR REFERRAL.

	PROVIDE SERVICE					
	OUT PATIENT	IN PATIENT	BOTH OUT AND IN	REFER ELSE WHERE	NO SERVICE/ NO REFERRAL	DON'T KNOW
A) Diagnosis and treatment of tuberculosis	1	2	3	4	5	8
B) Diagnosis and treatment of opportunistic infections	1	2	3	4	5	8
C) Palliative services (management of pain and terminal care)	1	2	3	4	5	8
D) Family planning services	1	2	3	4	5	8
E) Counseling on prevention of mother-to-child transmission	1	2	3	4	5	8
F) Antiretroviral prevention of mother-to-child transmission						
G) Psychosocial services	1	2	3	4	5	8
H) Counseling/training for home care	1	2	3	4	5	8
I) Antiretroviral therapy	1	2	3	4➔538	5➔538	8➔538

545	Does this facility have protocols on the following? FOR EACH, ASK IF THE PROTOCOL EXISTS AND ASK TO SEE A COPY.					
	A) Confidentiality protocol for HIV/AIDS Clients	1	2	3	8	
	B) Informed consent protocol for HIV/AIDS Clients	1	2	3	8	
	C) Written protocols for referrals for HIV/AIDS clients for care and support services	1	2	3	8	
546	Is there a register where information for HIV/AIDS clients receiving treatment is recorded? IF YES, ASK TO SEE THE REGISTER. DIAGNOSIS AND TREATMENT MUST BE RECORDED FOR THE REGISTER TO BE VALID.	YES, REGISTER SEEN ..... 1 YES, REGISTER NOT SEEN..... 2 NO REGISTER KEPT..... 3				 ➔548 ➔548
547	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS ..... 1 > 7 DAYS..... 2				

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
548	RECORD THE TOTAL NUMBER OF CLIENTS (NEW AND RETURNED) WHO RECEIVED ANY HIV/AIDS SERVICES DURING THE JANUARY-JUNE PERIOD (EXCLUDE VCT CLIENTS).	NUMBER OF HIV CLIENTS..... ☐☐☐ DON'T KNOW.....998	➔550
549	INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED.	☐☐ MONTHS OF DATA.....	
550	Does the facility have a mechanism to follow up on referrals? IF YES, ASK TO SEE ANY RECORD OR FORM RELATED TO FOLLOW UP. IF NO REFERRALS ARE MADE BECAUSE THIS IS A REFERRAL FACILITY, INDICATE "4."	YES, OBSERVED FORM.....1 YES, NO FORM SEEN.....2 NO.....3 REFERRAL FACILITY.....4 DON'T KNOW.....8	
551	Does the facility have a list of care and support services to which clients can be referred? IF YES, ASK TO SEE THE LIST.	YES, LIST SEEN .....1 YES, LIST NOT SEEN.....2 NO.....3 DON'T KNOW.....8	
552	Does the facility have a formal partnership with a support group for persons living with HIV/AIDS?	YES.....1 NO.....2	

		1=CONDUCT TEST 2=COLLECT SPEC-IMEN 3=SEND CLIENT ELSEWHERE 4=TEST NOT UTILIZED			
553	Does this facility have the capacity to run the following tests for STIs? IF NOT: Do you collect the specimen and send it elsewhere for the test or does the client have to go somewhere else for the test? (CHECK SECTION 6 FOR EQUIPMENT AND SUPPLIES REQUIRED FOR ANY TEST CONDUCTED IN THE FACILITY.)				
	A) Syphilis	1	2	3	4
	B) Gonorrhea	1	2	3	4
	C) Sputum test for tuberculosis	1	2	3	4
	D) HIV/AIDS	1	2	3	4
	E) CD4 count (HIV)	1	2	3	4
	F) HIV viral load	1	2	3	4

SECTION 6, Laboratory Diagnostics, OMITTED

Section 7. Availability of Contraceptive Supplies

FIND THE CHIEF PHARMACIST OR OTHER HEALTH WORKER RESPONSIBLE FOR CONTRACEPTIVE SUPPLIES AT THE FACILITY. IF DIFFERENT FROM THE INDIVIDUAL RESPONDING TO THE EARLIER SECTIONS, INTRODUCE YOURSELF.

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
700	Is there an inventory for the contraceptive supplies? IF YES, ASK TO SEE IT. IF NO INVENTORY EXISTS, ALL RESPONSES FOR (C) BELOW ARE "NOT DETERMINED" OR "8".	YES, OBSERVED ..... 1 YES, NOT SEEN ..... 2 NO 3	

ASK TO SEE THE FOLLOWING CONTRACEPTIVE SUPPLIES. FOR ALL ITEMS, FOR THE SPECIFIC ITEMS INDICATED, (A) CHECK FOR AVAILABILITY OF UNEXPIRED METHODS. IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. (B) INQUIRE IF THE METHOD HAS STOCKED OUT FROM THE ***PHARMACY*** IN THE LAST SIX MONTHS. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE.

		(A)	(B)
	CONTRACEPTIVE METHOD	OBSERVED W/EXPIRY DATE 1=AT LEAST ONE VALID 2=REPORTED AVAILABLE 3=STOCKED OUT 7=SERVICE NOT PROVIDED 8=NOT DETERMINED	***PHARMACY*** HAS STOCKED OUT IN THE LAST SIX MONTHS 1=YES or CURRENTLY ABSENT 2=NO 7=SERVICE NOT PROVIDED 8=DON'T KNOW
701	Pastillas	1 2 3 7 8	1 2 7 8
702	T de Cobre	1 2 3 7 8	1 2 7 8
703	Inyección	1 2 3 7 8	1 2 7 8
704	Norplant	1 2 3 7 8	1 2 7 8
705	Condones	1 2 3 7 8	1 2 7 8
706	Condones femeninas	1 2 3 7 8	1 2 7 8
707	Espermicidas	1 2 3 7 8	1 2 7 8
708	Diafragma	1 2 3 7 8	1 2 7 8

709_a	Is there a register tracking the number of contraceptives distributed, by method? IF YES, ASK TO SEE THE REGISTER.	YES, REGISTER SEEN ..... 1 YES, REGISTER NOT SEEN ..... 2 NO REGISTER KEPT 3	 →711 →711

710_	RECORD THE TOTAL NUMBER OF METHODS DISTRIBUTED FOR THE JANUARY-JUNE PERIOD. METHOD NOT PROVIDED…….. 99998 DON'T KNOW…….. 99999		➔711
711_	a. Pastillas ……. b. T de Cobre ……. c. Inyección ……. d. Norplant ……. e. Condones f. Condones femeninas g. Espermecidas h. Diafragma INDICATE THE NUMBER OF MONTHS OF DATA REPRESENTED. MONTHS OF DATA		
711	ARE CONTRACEPTIVE SUPPLIES STORED IN THE SAME LOCATION AS OTHER MEDICINES?	YES ..... 1 NO 2	➔715
	OBSERVE THE PLACE WHERE CONTRACEPTIVE SUPPLIES ARE STORED AND INDICATE THE CORRECT RESPONSE FOR EACH OF THE FOLLOWING CONDITIONS.		
712	Are the methods <u>off the floor</u> and protected from water?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
713	Are the methods protected from the sun?	YES ..... 1 NO ..... 2 DON'T' KNOW 8	
714	Is the room clear of any evidence of pests (rats, bats, etc.)	YES ..... 1 NO ..... 2 DON'T KNOW 8	

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
715	Does this facility determine the amount of each contraceptive required and order this amount, or is the amount that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS ..... 1 NEED DETERMINED ELSEWHERE 2	➔717
716	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply, or does the amount you receive vary with the activity level that you report?	AMOUNT BASED ON ACTIVITY LEVEL..... 1 STANDARD FIXED SUPPLY ..... 2 DON'T KNOW 8	➔719 ➔719 ➔719
717	How do you decide how much of each contraceptive to order? (IF UNCERTAIN, ASK QUESTIONS TO CLARIFY WHICH RESPONSE(S) MOST CLOSELY DESCRIBE(S) THE SYSTEM(S) USED.) A) ORDER TO BRING STOCK TO FIXED LEVEL B) ORDER THE SAME QUANTITY EACH TIME REGARDLESS OF HOW MUCH OF EACH METHOD REMAINS IN STOCK C) ORDER DIFFERENT AMOUNTS, BASED ON CALCULATIONS OF PRIOR UTILIZATION AND EXPECTED FUTURE ACTIVITY D) ORDER DEPENDING ON WHAT STAFF THINK IS NEEDED, WITHOUT A SPECIFIC METHOD FOR CALCULATING AMOUNTS W) OTHER (SPECIFY)_____ Z) DON'T KNOW	..... A ..... B ..... C ..... D ..... W ..... Z	
718	How do you decide when to order contraceptives? (IF UNCERTAIN, ASK QUESTIONS TO CLARIFY WHICH RESPONSE(S) MOST CLOSELY DESCRIBE(S) THE SYSTEM(S) USED.) A) PLACE AN ORDER WHENEVER STOCK LEVELS FALL TO A PRE-DETERMINED LEVEL. B) THERE IS A FIXED TIME WHEN STAFF ARE SUPPOSED TO SUBMIT ORDERS FOR CONTRACEPTIVES. IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. C) THE FACILITY CAN PLACE AN ORDER WHENEVER THERE IS BELIEVED TO BE A NEED, REGARDLESS OF STOCK LEVEL. W) OTHER (SPECIFY)_____ Z) DON'T KNOW	..... A ..... B EVERY ☐☐ WEEKS ..... C ..... W ..... Z	
719	During the past 3 months, have you always, sometimes or almost never received the amount of each contraceptive supply that you ordered (or that you are supposed to routinely receive?)	ALWAYS ..... 1 SOMETIMES ..... 2 ALMOST NEVER..... 3	

Section 8. Short List of Essential Medications

FIND THE CHIEF PHARMACIST OR OTHER HEALTH WORKER RESPONSIBLE FOR PHARMACEUTICAL SERVICES AT THE FACILITY. IF DIFFERENT FROM INDIVIDUAL RESPONDING TO THE EARLIER SECTIONS, INTRODUCE YOURSELF.

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
800	Is there an inventory for the medications? IF YES, ASK TO SEE IT.	YES, OBSERVED..... 1 YES, NOT SEEN ..... 2 NO..... 3	

MEDICATIONS: ASK TO SEE THE FOLLOWING MEDICATIONS. FOR THE SPECIFIC ITEMS INDICATED, (B) CHECK FOR AVAILABILITY OF UNEXPIRED ITEMS (IN ANY FORM). IF YOU ARE UNABLE TO SEE AN ITEM, ASK IF IT IS AVAILABLE. (B) INQUIRE IF THE MEDICATION IN HAS COMPLETELY STOCKED OUT FROM THE ***PHARMACY*** (NOT AVAILABLE IN ANY FORM) IN THE LAST SIX MONTHS. FOR EACH ITEM, CIRCLE THE APPROPRIATE CODE:

	ORAL MEDICATION	(A) OBSERVED W/EXPIRY DATE 1=AT LEAST ONE VALID 2=REPORTED AVAILABLE 3=STOCKED OUT 7=SERVICE NOT PROVIDED 8=NOT DETERMINED	(B) ***PHARMACY*** HAS STOCKED OUT IN THE LAST SIX MONTHS 1=YES or CURRENTLY ABSENT 2=NO 7=SERVICE NOT PROVIDED 8=DON'T KNOW
801	Trimetroprin Sulfa	1 2 3 7 8	1 2 7 8
802	Amoxicilina	1 2 3 7 8	1 2 7 8
803	Penicilina	1 2 3 7 8	1 2 7 8
804	Acetaminofen	1 2 3 7 8	1 2 7 8
805	Expectorante	1 2 3 7 8	1 2 7 8
806	Mebendazol	1 2 3 7 8	1 2 7 8
807	Metronidazol	1 2 3 7 8	1 2 7 8
808	Acido Folico	1 2 3 7 8	1 2 7 8
809	Vitamina A Capsulas	1 2 3 7 8	1 2 7 8

	OBSERVE THE PLACE WHERE MEDICINES ARE STORED AND INDICATE THE CORRECT RESPOSE FOR EACH OF THE FOLLOWING CONDITIONS.		
890	Are the medicines <u>off the floor</u> protected from water/dampness?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
891	Are the medicines protected from the sun?	YES ..... 1 NO ..... 2 DON'T' KNOW 8	
892	Is the room clear of any evidence of pests?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
893	Does this facility determine the amount of each medication required and order this amount, or is the amount that you receive determined elsewhere?	DETERMINES OWN NEED AND ORDERS ..... 1 NEED DETERMINED ELSEWHERE 2	→895
894	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the amount you receive vary with the activity level that you report?	AMOUNT BASED ON ACTIVITY LEVEL..... 1 STANDARD FIXED SUPPLY ..... 2 DON'T KNOW 8	→897 →897 →897

895	How do you decide how much of each medication to order? (IF UNCERTAIN, ASK QUESTIONS TO CLARIFY WHICH RESPONSE(S) MOST CLOSELY DESCRIBE(S) THE SYSTEM(S) USED) A) ORDER TO BRING STOCK TO FIXED LEVEL B) ORDER THE SAME QUANTITY EACH TIME REGARDLESS OF HOW MUCH OF EACH VACCINE REMAINS IN STOCK C) ORDER DIFFERENT AMOUNTS, BASED ON CALCULATIONS OF PRIOR UTILIZATION AND EXPECTED FUTURE ACTIVITY D) ORDER DEPENDING ON WHAT STAFF THINK IS NEEDED, WITHOUT A SPECIFIC METHOD FOR CALCULATING AMOUNTS W) OTHER (SPECIFY)_____ Z) DON'T KNOW	.....A .....B .....C .....D .....W .....Z	

NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
896	How do you decide when to order medicines? (IF UNCERTAIN, ASK QUESTIONS TO CLARIFY WHICH RESPONSE(S) MOST CLOSELY DESCRIBE (S) THE SYSTEM(S) USED.) A) PLACE AN ORDER WHENEVER STOCK LEVELS FALL TO A PREDETERMINED LEVEL. B) THERE IS A FIXED TIME WHEN STAFF ARE SUPPOSED TO SUBMIT ORDERS FOR MEDICINES. IF YES, INDICATE THE NORMAL FIXED TIME FOR SUBMITTING ORDERS. C) THE FACILITY CAN PLACE AN ORDER WHENEVER THERE IS BELIEVED TO BE A NEED, REGARDLESS OF STOCK LEVEL. W) OTHER (SPECIFY)_____ Z) DON'T KNOW	..... A ..... B EVERY ☐☐ WEEKS ..... C ..... W ..... Z	
897	<u>During the past 3 months</u>, have you always, sometimes or almost never received the amount of each medication that you ordered (or that you are supposed to routinely receive)?	ALWAYS ..... 1 SOMETIMES ..... 2 ALMOST NEVER 3	

901	RECORD TIME INTERVIEW ENDED.	HOUR ..... ☐☐ MINUTES ..... ☐☐	
902	INTERVIEWER COMMENTS:		

Annex C: Derivation of Salary Calculations

To estimate salary expenditures per facility and per thousand population, the following steps were used:

1. Calculate the total number of clinical staff for the facility paid from MSPAS funds, by staff category (doctors, nurses, nurse aux.)

   a. "Other Clinical" staff were excluded from the estimates (facilities average only 0.56 other clinical personnel and 0.38 are paid from MSPAS funds)

   b. No data were collected for support personnel (groundskeeper, security, etc.). Not including these personnel will not bias the results since most were paid through cost recovery and not from Ministry funds.

2. Multiply total number of staff in each category by the average MSPAS salary for each category (see example for more detail).

3. Calculate salary expenditures by summing salary expenditures for each staff category:

   a. Facility-based personnel: doctors, nurses, nurse auxiliaries, and dentists

   b. Community-based personnel: health promoters and health inspectors

   c. Total MSPAS salary expenditures (a+b)

4. Divide total expenditures by the population assigned to that facility to produce salary expenditures per capita.

Although the calculations use the actual facilities, the example will use and discuss the "average" facility in these seven SIBASI.

Step #1: Calculate the total number of clinical staff paid from MSPAS funds.

Table A.1: Average Staff per Primary Care Facility

Staff Category	Staff Paid by MSPAS Funds	Total Staff**
Facility-based staff		
Doctors	1.7	2.6
Dentists	0.5	0.9
Nurses	0.8	1.0
Nurse auxiliaries	1.6	1.9
Other Clinical*	0.4	0.6

Staff Category	Staff Paid by MSPAS Funds	Total Staff**
Community-based staff		
Health promoters	4.2	4.2
Health inspectors	1.0	1.0

*. Other clinical staff were excluded from the salary calculations.
**. Total staff are only given for reference. The goal of the salary derivation is to determine the amount spent on salaries from central Ministry funds.

Step #2: Multiply total number of staff in each category by the average MSPAS salary.

To estimate salary expenditures, it was necessary to calculate an average salary for each staff category. For those calculations, the following information was drawn from the El Salvador 2002 salary law. For each appointment, the list gives the name of the appointment, hours per day that will be paid, minimum salary for the appointment, maximum salary for the appointment after incorporating years of service with MSPAS, and total number of those appointments in all of MSPAS. Each category of staff has multiple appointments, but these differences are usually the number of hours that will be paid.

Appointment Name and Line Number		Hours per day	Minimum Monthly	Max. Monthly	Plazas
79	Médico Director de Unidad de Salud	8	969.15	1540.95	121
86	Médico Director de Unidad de Salud (6 horas diarias)	6	726.86	1155.71	17
102	Médico Director de Unidad de Salud (4 horas diarias)	4	484.58	770.48	7
150	Médico Director de Unidad de Salud (2 horas diarias)	2	242.29	385.24	40
87	Médico Subdirector de Unidad de Salud (6 horas diarias)	6	726.86	1155.71	3
97	Estudiante de Medicina en Servicio Social	*8*	512.58	512.58	366
	PROMEDIO: Médico Principal	7.44	600.17	754.47	554
88	Médico de Consulta General (6 horas diarias)	6	726.86	1155.71	6
103	Médico de Consulta General (4 horas diarias)	4	484.58	770.48	17
149	Médico de Consulta General (10 horas semanales)	2	242.29	385.24	14
151	Médico de Consulta General (2 horas diarias)	2	242.29	385.24	305
156	Médico de Consulta General (1 horas diarias)	1	121.15	192.63	1
	PROMEDIO: Médico de Consulta General	2.17	262.42	417.25	343
91	Enfermera Supervisora Local		627.43	997.61	86
95	Enfermera		585.15	930.39	22
96	Enfermera de Unidad Movil Rural		556	884.04	40
99	Enfermera Comunitaria		502.29	798.64	322
	PROMEDIO: Enfermera		533.64	848.48	470
101	Auxiliar de Enfermería de servicios especializado		499.43	794.09	61
109	Auxiliar de Enfermería de Salud Comunitaria		425.15	675.99	677

	PROMEDIO: Auxiliar de Enfermería		431.29	685.75	738
89	Odontólogo (6 horas diarias)	6	726.86	1155.71	12
104	Odontólogo (4 horas diarias)	4	484.58	770.48	1
152	Odontólogo (2 horas diarias)	2	242.29	385.24	47
153	Odontólogo Docente Asistencial (2 horas diarias)	2	242.29	385.24	33
	PROMEDIO: Odontólogo	2.54	307.42	488.80	93
98	Estudiante de Odontología en Servicio Social	8	512.58	512.58	128
146	Estudiante de Odontología en Servicio Social (4 horas diarias)	4	256.58	256.58	62
	PROMEDIO: Estudiante de Odontología	6.69	429.04	429.04	190
120	Supervisor de Promotores de Salud		369.72	587.85	53
127	Promotor de Salud		305.15	485.19	1585
	PROMEDIO: Promotor de Salud		307.24	488.51	1638
118	Inspector Técnico en Saneamiento Ambiental		388.00	616.92	13
115	Educador para la Salud (nivel local)		399.43	635.09	1

A weighted average was calculated for each category of staff. For the first group, health center directors (Médico Director de Unidad de Salud), the average minimum salary would be 600 colones per month for 7.4 hours of work. Appointments for nondirector physicians paid an average of 262 colones for 2.2 hours of work.

From the above list (average used marked in bold), salary expenditures used the following average salaries:

Doctor:	600 colones per month	(US$ 68.57)
Nurse:	534 colones per month	(US$ 61.03)
Nurse Aux:	431 colones per month	(US$ 49.26)
Dentist (student):	429 colones per month	(US$ 49.03)
Health Promoter:	307 colones per month	(US$ 35.09)
Health Inspector:	388 colones per month	(US$ 44.34)

For consistency, all estimates use the minimum monthly salary, unadjusted for years of service with MSPAS. Since the average facility has only 1.7 MSPAS paid appointments for doctors, the higher facility director salary was applied to each.

With this information, Table A.1 can be amended to include salary information. Step 3 can easily be included as a separate row.

Table A.2: Salary Expenditures by MSPAS at the Average Primary Care Facility

Staff Category	Staff Paid by MSPAS Funds	Estimated MSPAS Salary Expenditures Colones/mo	Percent of Total Salary Expenditures
Facility-based staff			
Doctors	1.7	1,020	25%
Dentists	0.5	214	5%
Nurses	0.8	427	11%
Nurse auxiliaries	1.6	690	17%
Total Facility Based		**2,351**	**58%**
Community-based staff			
Health promoters	4.2	1,289	32%
Health inspectors	1.0	388	10%
Total Community Based		**1,677**	**42%**
Total Salary Expenditures		**4,028**	**100%**

This estimate for average salary expenditures differs from that in the text since this estimate is based on the average number of staff and the text estimate is an average of the individual facility expenditures.

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